

PDHM-091

96956

# MID-TERM EVALUATION OF THE HEALTH FINANCE DEVELOPMENT PROJECT

July 27, 1994

Prepared by: Chris Hermann, Team Leader  
Harry Cross, Health Economist  
Carmencita Abella, Institutional Analyst

Under Contract No. 492-0446-0-00-4063  
with USAID/Philippines

This evaluation was completed through the assistance of the United States Agency for International Development (A.I.D.). The views, expressions and opinions contained in the report are the authors' and are not intended as statements of A.I.D.

## ACRONYMS

AC	Andersen Consulting
CARRA	Corporate Assistance and Research Associates
CHCA	Comprehensive Health Care Agreement
DLLO	Department Legislative Liaison Office
DOH	Department of Health
ECC	Employees Compensation Commission
FY	Fiscal Year
GOP	Government of the Republic of the Philippines
GSIS	Government Service Insurance System
HCF	Health Care Finance
HFDPP	Health Finance Development Project
HIID	Harvard Institute for International Development
HMO	Health Maintenance Organization
HOMS	Hospital Operations and Management Service
HPDS	Health Policy Development Staff
IE&C	Information, Education and Communication
IPS	Internal Planning Service
IRR	Implementing Rules and Regulations
LGAMS	Local Government Assistance and Monitoring Service
LGC	Local Government Code
LGU	Local Government Units
MAS	Management Advisory Service
MIS	Management Information System
MSH	Management Sciences for Health
NGO	Non-government Organization
NHA	National Health Accounts
NHADB	National Health Accounts Data Base
NHI	National Health Insurance
NHP	National Health Plan
O/PHN	USAID's Office of Population, Health and Nutrition
PMCC	Philippine Medical Care Commission
PSC	Personal Services Contract(or)
RFP	Request for Proposals
RUV	Relative Unit Value
SLR	Standards, Licensing and Regulations
SSS	Social Security System
TOR	Terms of Reference
U.P.	University of the Philippines
UPecon	University of the Philippines Foundation
USAID or A.I.D.	United States Agency for International Development

## EXECUTIVE SUMMARY

The Health Finance Development Project (HFDP) responds to the increasingly important health care finance requirements of the Philippines. The goal of HFDP is to develop the health care market in order to improve health service quality, equity, coverage, efficiency and private participation. The purpose of HFDP is to establish a process for formulating and implementing health sector policies, regulations and legislation supportive of health-care market improvements.

HFDP was approved in September 1991 with a total budget of \$26,855,000. USAID contributed \$20 million with the balance made up of counterpart funding. Due to budget cuts in USAID's program level, funding had to be reduced to \$11.7 million with a comparable reduction in GOP counterpart funding. This resulted in significant reductions in planned technical assistance, training, studies and demonstrations. Budget cuts combined with the need to realign the activities of HFDP with new DOH priorities led to a re-focusing of the project in five program areas: National Health Insurance; Public Resource Management; Devolution of Health Services; Standards, Licensing and Regulation; and the Health Policy Process. The re-focusing exercise resulted in a modified project structure but the new emphases of HFDP remained consistent with the project's original goal and purpose.

HFDP activities are implemented through a USAID direct contract with Management Sciences for Health (MSH) and a cooperative grant agreement with the UPecon Foundation. After the budget reduction, \$5.7 million will be channelled through the MSH contract and \$3.6 million through the UPecon grant. Both the contract and the grant were shortened by one year, now scheduled for completion in September 1995. However, HFDP's completion date remains to be September 30, 1996 as planned and re-allocation of funds from the contract and grant augmented by funds currently held in reserve by USAID can continue activities during FY 96, the final year of HFDP.

The purpose of this mid-term evaluation is to: a) examine the continuing validity of the amended project and its objectives in light of recent changes in the health sector and the current direction of the DOH, and b) assess the management, administrative and operational systems of the project with respect to their facilitating the achievement of project objectives.

Overall, HFDP has to date produced many useful products which have contributed to a better understanding and awareness of HCF issues among decision makers in both the public and private sectors. To maximize the utility of these products, key findings and recommendations need to be distilled and disseminated widely.

## 1. Assessment of Project Validity:

### 1.1 Revised Project Objectives

The five program areas provided focus to HFDP activities and made the project more responsive to the immediate operational issues confronting the DOH. Whereas HFDP originally supported both sectoral and operational policies, the re-focused project concentrates resources on operational issues to a much greater extent. Nevertheless, the five current program areas still address key health policy financing needs. It is difficult to assess whether other focus areas could produce greater impact on health care financing problems. However, HFDP had probably become engaged in too many areas. The re-focusing, therefore, served to concentrate project resources to address a more limited number of problems more thoroughly. No change in the current configuration of program areas is recommended.

### 1.2 Project Strategies

In the area of **National Health Insurance**, HFDP has provided essential assistance to the process of developing the Senate's National Health Insurance bill. HFDP can play an equally important role in the actual design of the national insurance program once legislation is passed. The project has set the stage for major, positive reforms in the administration of Medicare through its studies, recommended operational improvements and work on Medicare II. However, the results of this work need to be distilled and conveyed to managers of the Medicare system. Substantial technical assistance will be needed for demonstration activities especially for evaluating the results. More attention to the linkage between health status and the various financing schemes is needed, particularly with respect to outpatient care.

HFDP responded effectively to assist the DOH to begin meeting the challenges it faces in the area of **Devolution**. The Comprehensive Health Care Agreements promise to be an effective mechanism for managing the new DOH - LGU relationship. Work in this area needs to be distilled and disseminated.

The work supported by HFDP in the area of **Public Resource Management** represents a solid step in the direction of rationalizing the DOH's budget process. Strategic financial planning by IPS, the development of a National Health Plan and the preparation of a 10-Year Investment Plan are each worthwhile undertakings; however, the project needs to consider how much of its resources it should devote to this in light of competing demands for project resources, especially after September 1995.

HFDP has been able to accomplish a considerable amount in the area of **Standards, Licensing and Regulations**, especially given that only one technical advisor has been involved in this area. The project has helped managers improve their strategic planning skills in this area. Work completed on retained hospitals is largely applicable to devolved hospitals, as is the work on strengthening the preventive/promotive capacity of hospitals.

HFDP needs to review planned activities in this area to assure planning matches resource availability, evaluate the revenue enhancement demonstrations and disseminate the results of this work and strategic planning materials widely.

The various research and policy analyses conducted by the project have had varying impact in the area of Health Policy Development. Nevertheless, a great deal of potentially useful research has been completed. Some institution building has occurred, although not to the degree desired by the DOH. HPDS' status within the DOH remains contingent on finalizing the DOH's re-organization plan. Work on the National Health Accounts Data Base, the Multisectoral Forum and training related to health policy development have all made useful and important contributions. Work completed in this area also needs to be distilled and disseminated to maximize its utility.

### 1.3 Project Environment

Major changes in the political and institutional environment in which HFDP has operated have created both challenges and opportunities for the project. The implementation of the Local Government Code and devolution of health services, the Magna Carta for health workers, a new DOH administration with new priorities and directions, and USAID budget cuts have all affected HFDP's implementation. The project has responded successfully to these demands through the recently completed re-focusing exercise. However, given delays in the start-up of activities combined with the reduction in technical assistance, potentially serious consequences are foreseeable. HFDP managers need to give priority to completing activities with the highest potential impact within the remaining period of long-term technical assistance.

### 1.4 Actual and Potential Impact

HFDP has raised awareness and understanding of health finance policy issues, begun the process of creating local capacity to analyze and influence health policy formulation, influence the allocation of resources to the health sector, identified barriers to greater efficiency in the Medicare system, developed management tools for health services in the devolved public sector, improved budgeting and planning processes in the DOH, and enhanced prospects for revenue retention in Public Hospitals. Dissemination of the results of this work in useable forms will be key to converting potential to actual impact.

### 1.5 Implementing Structure

Measured by the sheer number of project outputs, no changes are needed in the present implementation structure of HFDP. Project management should determine where the PSC's involvement in technical work could be expanded further.

## 2. Assessment of Management Structures and Processes

### 2.1 Pace of Implementation

MSH's failure to expedite local contracting for studies and demonstrations will reduce the overall impact of the project. The reduction in HFDP's level of effort compounds MSH's problems in this area. Shifting DOH priorities and a less than optimal DOH administrative structure also slowed the pace of the project.

### 2.2 Constraints and Opportunities

The major vulnerability HFDP confronts is the tenuous capacity of DOH units to sustain health finance policy activities after project completion in 1996. PMCC has gained capacities, such as providing assistance to health insurance programs at the provincial level, which were weak or lacking prior to the project. Despite support for health policy work by the Undersecretary and Chief of Staff, a lack of trained staff, work time free of competing demands and minimal institutional influence of HPDS in the Department have setback efforts to institutionalize the policy development process. Better use of trained staff combined with sufficient time to work on policy-related assignments are recommended. HFDP has also made progress toward developing local HC<sup>7</sup> expertise, but this needs further support. The evaluation recommends modifying the scope of the UPecon cooperative agreement to align future activities with the operational requirements of the project and extending the revised grant agreement until the September 30, 1996 PACD using remaining project funds.

### 2.3 Administrative Structures

The DOH's current administrative structure, which reflects the re-focusing exercise, resolved previous problems and need no further improvement at this time. MSH needs to make every effort to hire someone as their new Administrative Officer who has strong contracting skills. UPecon project administration arrangements need a major change to improve their effectiveness. The evaluation recommends shifting the role of the current Project Director to the status of a consultant to the project and hiring a new Project Director who has the full confidence of senior DOH managers.

## TABLE OF CONTENTS

		Page
Acronyms		i-iv
Executive Summary		1
1.	Overview of the Health Finance Development Project	5
2.	The Purpose and Method of the Evaluation	6
3.	Assessment of Project Validity	6
3.1	Revised Project Objectives	10
3.2	Project Strategies	10
3.2.1	National Health Insurance	16
3.2.2	Devolution	19
3.2.3	Public Resource Management	21
3.2.4	Standards, Licensing and Regulation	24
3.2.5	Health Policy Process	28
3.3	Changes in Project Environment	32
3.4	Actual and Potential Impact	33
3.4.1	Macro Level Policy Impacts and Potential Impacts	36
3.4.2	Operational Policy Impacts and Potential Inputs	38
3.5	Implementing Structure	41
4.	Assessment of Management Structures and Processes	41
4.1	Pace of Project Implementation	47
4.2	Constraints and Opportunities	49
4.2.1	Technology Transfer, Institutionalization and Sustainability Concerns	55
4.2.2	Strengthening the Gains Made Toward Building Local HCF Expertise	58
4.3	Administrative	58
Annex 1	Scope of Work	
Annex 2	Individuals Interviewed	
Annex 3	Revised Project Description	

## 1. Overview of the Health Finance Development Project

The Health Finance Development Project (HFDP) responds directly to the fundamental problems the Philippines confronts concerning health care financing. Meeting the health needs of all, or even most, Filipinos is simply beyond the means of the government. Current government expenditures for health in the Philippines is low even by developing country standards. Moreover, macroeconomic constraints make it unlikely that the government could increase its financing for health substantially any time soon. The urgency of addressing health care financing (HCF) issues is inescapable in light of the country's rapidly expanding population, the escalating costs of health care and demographic changes which are increasing demand for more expensive curative services. Furthermore, whatever short-term gains might be made in service delivery to the general public, such as increased immunizations, will be undone by unresolved HCF requirements over the longer-term.

The financial implications of demographic trends and HCF requirements clearly point to the need for greater investment in the health sector, as well as greater efficiency in the use of existing resources, to meet health needs. Given the government's budgetary limitations, these investments will increasingly have to come from the private sector if health needs are to be met in the foreseeable future. HFDP was designed to support the development of processes, systems and institutional capacities necessary to formulate and implement health finance policies which are needed to encourage private sector development.

HFDP was approved in September 1991 with the goal of developing the health care market in order to improve health service quality, equity, coverage, efficiency and private participation. HFDP's development purpose was to establish a process for formulating and implementing health sector policies, regulations and legislation supportive of health-care market improvements.

HFDP was initially authorized at a total cost of \$26,855,000, consisting of \$20 million from USAID with a GOP counterpart contribution of \$6,855,000. The bulk of USAID's funding would be used for technical assistance, studies and research, field demonstrations/pilot testing of health care financing schemes, local and U.S.-based short and long-term training, communications (e.g., workshops, publications, public fora) and commodities (computers and software, office equipment).

HFDP was amended in April 1994 to accommodate reductions in USAID/Philippines' program funding and to bring the project in line with the prevailing interests and direction of the DOH under the Flavier Administration. However, it is important to understand the changes made to HFDP in light of the original structure of the project.

To achieve HFDP's goal and purpose, project resources supported an array of activities within three main components: Policy Formulation, Health Care Financing Mechanisms and Hospital Financing Reforms.

The Policy Formulation component provided assistance to strengthen the GOP's capacity for research-based policy formulation and to establish mechanisms for transparent health care

financing policy processes. Moreover, the policy formulation process would be interactive, i.e., policies would be developed which involved the interaction of the private and public health care sectors. The Department of Health (DOH) established the Health Policy Development Staff (HPDS), mandated to be the center of this policy formulation process. To support research-based policy analysis, as well as subsequent monitoring and evaluation of health finance policies, HFDP would develop a National Health Accounts Data Base (NHADB). The interactive nature of the policy process would be advanced through the establishment of a Multisectoral Health Policy Forum. The Forum would offer an opportunity for open discussion among the various constituent organizations and agencies from the private and public sectors involved with particular policies under development or revision.

Assistance in this area was provided through a cooperative grant agreement with the UPEcon Foundation based at the University of the Philippines School of Economics. An important part of UPEcon's assistance is to help HPDS gain the capacity to carry-out its responsibilities for policy formulation, monitoring and evaluation. UPEcon's work on HFDP commenced in February 1992.

The Health Care Financing Component focused principally on Medicare I reforms and, more recently, on the development of the Medicare II program. Work under this component was directed to finding the ways and means to improve the efficiency and coverage of the Medicare program. The Philippine Medical Care Commission (PMCC) is the counterpart organization for this component. Development of alternative health care financing (HCF) schemes, such as employer-provided benefit packages, community financing programs and private risk-sharing programs were also part of this component. Assistance to the DOH to formulate draft legislation for a National Health Insurance Bill is a significant element of Component 2.

Hospital Financing Reforms responded to a key health finance issue of improving the management of public and private hospitals. HCF issues figure prominently in this area. Approximately sixty percent of the DOH's annual budget was for hospital operations and services and many people, particularly the poor, receive their only medical attention at hospitals. Work under this component focused on improving the efficiency and effectiveness of hospital-based care provided through public and private hospitals in the Philippines. The Local Government Code (LGC) gave added importance to this component. In particular, Local Government Units (LGUs) needed guidance concerning management of devolved hospitals facilities for which they are now responsible.

The Health Care Financing Mechanisms and the Hospital Financing Reforms Components were implemented through a competitive contract awarded to Management Sciences for Health (MSH) with Andersen Consulting (AC), Corporate Assistance and Research Associates (CARRA) and the Harvard Institute for International Development (HIID) as sub-contractors to MSH. The MSH team commenced work in July 1992.

The underlying strategy to establish a transparent and interactive policy process guided activities within these components. That strategy consisted of five major steps. First, an assessment of issues, existing information and the perspectives and concerns of public and private agencies would be conducted as a starting point for planning the next step of research and studies. The results of the studies would generate information relevant to further policy dialogue among the concerned agencies and organizations. This would lead to identifying possible options for policy formulation, followed by pilot testing or field demonstrations to determine the effectiveness of the policy. The results of these demonstrations would then culminate in the formulation of the most promising HCF policy which, once implemented, would be monitored and evaluated over time. The entire process might take anywhere from eighteen months to several years to reach the policy implementation stage.

In support of this process, research, studies, demonstrations and facilitation of policy dialogue constituted core activities for the UPecon and MSH teams and their DOH and PMCC counterparts. This work was conducted by the UPecon and MSH teams, or they contracted with local firms and individual consultants to carry out HFDP activities. Institutional development activities, such as short and long-term training and technical assistance to the DOH and PMCC, were envisioned as transferring technologies and building capabilities so that these organizations could sustain the policy formulation process. Engaging local consulting firms and individual consultants, as well as utilizing UPecon and CARRA (a newly established local consulting company) to implement the project, would also contribute to forming a "critical mass" of local expertise to carry on HCF work after project completion. Institutionalization of capabilities, combined with this "critical mass" of local expertise is fundamental to achieving project sustainability, i.e., sustaining the policy formulation process.

For budgetary and programmatic reasons, HFDP was amended in late 1993. The amendment specified five program areas for HFDP's remaining assistance which correspond more closely to the DOH's prevailing interests and direction. These are: National Health Insurance; Public Resource Management; Devolution; Standards, Licensing and Regulation; and Health Policy Process. The Health Policy Process and National Health Insurance areas largely continue the work under the former Components 1 and 2 respectively. The Standards, Licensing and Regulations (SLR) program area utilizes the work conducted under former Component 3 with particular attention to the devolution of hospital facilities and their management. Work in this area is targeted on improving efficiency in retained devolved and private hospitals, assuring fiscal and service standards in devolved hospitals and building capacity for SLR oversight in the DOH.

Assistance in the areas of Devolution and Public Resource Management had begun prior to the re-focusing exercise. Assistance in the Devolution Program Area focuses on the fiscal policy and financial management of devolved health facilities, development of new DOH-LGU working relationships for service delivery via Comprehensive Health Care Agreement (CHCA) and DOH assistance to LGUs to help them provide quality health services. Public Resource Management supports development of DOH strategic financial planning, including

annual budgeting, and long-range investment planning, development of a national health plan and options for re-organizing the DOH.

Unlike the previous arrangement where UPecon was responsible largely for Component 1 and MSH for Components 2 and 3, both teams will undertake tasks in the five program areas. The management structure of the project, particularly for the DOH, has been changed to reflect the five program areas. This change resulted in a more direct linkage between project activities and specific client-users in the DOH and PMCC, as well as streamlined administrative arrangements.

The five program areas were viewed as wholly consistent with HFDP's original objectives; therefore, the goal and purpose of the project remain the same. However, USAID's contribution to the project was reduced to \$11.7 million with a corresponding reduction in GOP counterpart funding. This translates into substantial reductions in the number, range and scope of activities initially planned under HFDP. Total funding for MSH's contract was reduced from \$10 million to \$5.7 million, and UPecon's grant fell from \$5.1 million to \$3.6 million. Both the contract and the grant will now terminate on September 30, 1995, one year prior to the project completion date. Programmatic plans for the work of the MSH and UPecon teams through September 31, 1995 have been completed and approved. The expected outputs within the five program areas correspond to those of the original three components, but they have been scaled back to accommodate the reduced budget of HFDP. Annex 3 provides a more detailed discussion of the five program areas and their expected outputs.

## 2. The Purpose and Method of the Evaluation

This mid-term evaluation was conducted in June/July 1994 over four weeks involving the following individuals for differing periods of time: health finance specialist - Harry Cross for two weeks; institutional analyst - Carmencita Abella for two weeks; and management and evaluation specialist - Chris Hermann for four weeks. The amount of time allotted to Mr. Cross and Ms. Abella was sufficient to respond to the scope of work. At the time of the evaluation, the re-focusing exercise had been completed by USAID and the DOH and the effects of the changes to HFDP were beginning to become apparent.

The purpose of the evaluation is to: a) examine the continuing validity of the amended project and its objectives in light of recent changes in the health sector and the current direction of the DOH; and b) assess the management, administrative and operational systems of the project with respect to their facilitating the achievement of project objectives. Given the substantial changes recently made to HFDP through the re-focusing exercise, the evaluation concentrates principally on verifying the soundness of those revisions and recommending further improvements where necessary.

The evaluation is based on interviews with individuals from USAID, DOH, PMCC, and the technical assistance teams. Due to the staggered work schedule of the team, certain individuals were interviewed twice for different purposes. The evaluation suffers from a lack of access to the principal UPEcon representative, the Project Director, who was available to the team during the first week of the evaluation and was interviewed only once by two of the team members. No follow-up was possible prior to drafting the report. A key person at PMCC heavily involved with operational aspects of HFDP was also unavailable to the team. The evaluation benefitted from interviews with the MSH advisors prior to their departure from the Philippines. A comprehensive review of all studies, reports and technical notes produced by the project was not possible in the time available. Therefore, a sample of these materials were used to assess their technical quality and potential utility. All USAID project files pertaining to the management and administration of HFDP were also reviewed.

Annex 1 contains the scope of work for the evaluation. The report is organized by the questions given the team and are stated at the beginning of the corresponding response prepared by the team. These questions define broad areas or issues for the team to examine. This gave the team the latitude to determine which specific issues warranted particular attention or emphasis under each of the evaluation questions.

### 3. Assessment of Project Validity

#### 3.1 Revised Project Objectives

*How have project objectives been revised since 1991, and do the revised objectives reflect current needs in the health sector?*

##### *Findings:*

All studies of the Philippines, especially comparative studies among Asian countries, point to the low level of health financing for basic health care. This low level has created a number of problems for the health sector including strong competition for scarce public funds between the curative services and the preventive/primary services. The low level of financing also means that large numbers of lower income groups have limited access to adequate health care. Other problems cited in the literature on the Philippines include inefficiencies in allocations at the tertiary and secondary levels in both the public and private sectors (macro and micro levels), ineffective existing health financing mechanisms, rising demand for health services both for demographic and epidemiological reasons, underspending on preventive and primary care, and rising costs.

The range of health financing issues identified by project designers included *macro* policy reforms such as universal coverage, taxation, regulation, payment systems, and structural organization. The spectrum of issues also included *operational* reforms that address how current systems function, such as claims processing, reimbursement levels, quality assurance, and service delivery. The inclusion of operational policies in the project mandate opened up a huge array of potential activities for the project implementors.

At the same time that these macro and operational issues were identified as barriers to better health care, the project designers also realized that there was very little information available to assess problems and policies, there were few formal mechanisms for informing policymakers and private leaders on key issues. Little institutional capacity existed in government agencies or NGOs to analyze issues, stimulate reforms and improvements, sponsor new financing mechanisms, and evaluate the impacts of policy changes.

HFDP was designed in 1991 to respond to a growing recognition by the DOH, PMCC, affiliated government agencies, USAID, and private entities that these financing issues were central to improvements in the health sector. The goal of the project, therefore, was to "improve the health care market" by creating a positive policy environment.

Project designers took an innovative approach to improving health policies by arranging to strengthen the policy development process-at every stage. Simply stated, the project would help create the wide range of information and analysis required to understand health finance policies. This data and analysis would then be fed into policy dialogue and discussion, and would serve to educate and motivate bureaucrats, politicians, and public and private providers. Greater levels of awareness and understanding, in turn, would stimulate health financing policy reforms aimed at better service quality, increased equity and efficiency, and more private sector participation.

A key feature of the original design included a "demonstration," (or operational research) component that would permit experimentation and testing of proposed health financing policies and mechanisms. The importance of this element to project designers is evident in the project budget which allocated a fifth of the original project budget directly to sub-contracts and grants for demonstrations. Substantial amounts of project staff time were envisioned to develop, monitor, and evaluate these demonstrations.

The combination of new technical information and analyses, policy dialogue, and demonstrations was expected to result in a series of major reforms and innovations related to the Medicare Program, the financing of private providers, and improved efficiency among hospitals. Most importantly, the project had as a key objective to institutionalize the health finance policymaking "system." This was to be accomplished through the establishment and strengthening of policy offices in the DOH and the PMCC, and through greater involvement of the private sector in health policy development related to financing. The institutionalization of the health financing policy process would guarantee continued improvement in the policy environment long past the end of this five-year effort.

Project activities were organized under three broadly-defined, general components. Component 1 was concerned with building the capacity for research-based policy formulation, and the establishment of the health financing policy process. Component 2 aimed at expanding health coverage through improvements in health financing mechanisms in the public and private sectors. Component 3 was focused on affecting financing improvements in hospitals. The HFDP operated under these components and the above tenets for a period of about 18 months (June 1992 - November 1993).

As a result of changing government priorities and USAID budget reductions discussed in Section 3.3, HFDP managers in the DOH, USAID and the cooperating agencies reorganized the project into five program areas. The core activities of the previous three components were preserved and narrowed to respond to the exigencies of the day, and two new program areas were added. The five new focus areas respond to current DOH priorities and are comprised of the following:

- 1) *National Health Insurance (NHI)* - This corresponds roughly to Component 2 of the original project design, and includes Medicare reforms, demonstrations,

capacity building at the PMCC, and support to the development of National Health Insurance,

- 2) *Devolution* - The objective of this area is to provide assistance to the DOH to handle fiscal policies related to the devolution of health facilities.
- 3) *Standards, Licensing and Regulations (SLR)* - Refocused project activities in this area are aimed at improving efficiency in retained DOH hospitals, assuring fiscal and service standards in devolved hospitals, and building capacity for SLR oversight in the DOH.
- 4) *Public Resource Management* - This set of activities supports strategic planning in the DOH to include financial planning and budgeting, long-range investment plans, a national health plan, and options for reorganizing the structure of DOH.
- 5) *Health Policy Process* - This area corresponds to Component 1 of the original project, but narrows the technical activities and focusses on building institutional capacity at the DOH. It also includes several activities aimed at fostering policy dialogue such as the Multisector Health Policy Forum.

In a period of several months, all project activities were either reclassified into one of these five program areas, or eliminated altogether. The contractual and grant agreements were renegotiated with the cooperating agencies which had the effect of reducing the overall budget and terminating the agreements in September 1995 instead of September 1996. A new operational plan for the entire project was approved in early 1994 to cover the remaining 18 months of the existing agreements.

Thus, the original five-year project with three technical components became a four-year project with two distinct technical phases.

### *Conclusions:*

In the original HFD Project, USAID and the DOH proposed a highly rational, well-conceived project aimed at addressing many of the shortcomings of the health financing policy process. In a sense, the project was an *ideal* way to deal with health financing in the Philippines, and it is difficult to find fault with the conceptual approach. The project designers even recognized that reforming health financing policy requires a long-term investment as is indicated by the provision for an additional five year s of funding in the event that the first five-years produced significant progress.

The institutional environment in which the original project was designed was highly supportive of HFDP's strategy. USAID development assistance strategy strongly encouraged health financing, the DOH senior management welcomed the project, and there were

qualified technical staff to design the effort. Improving the policy environment for health markets was a priority of both parties.

With the change of GOP administration in June 1992, the environment for the project shifted. DOH priorities moved to shorter-term concerns as the requirements of the political landscape changed. These new requirements included the immediate consequences of devolution, including operational and budgeting issues, and the imminent introduction of national health insurance bills. The new environment brought some of the originally identified issue areas in to greater relief. The five "new" areas of concentration were defined, and the project had to become more responsive to the immediate needs of the DOH while at the same time pursuing its longer-term objectives. Thus, while the original project addressed both macro and operational policy issues, the re-cast program areas clearly shifted the emphasis to operational policies.

Whereas the current five program areas do not fit so effortlessly into the conceptual framework of the original project, they nevertheless still address key health policy financing needs of the country. As such, the project and its new program areas remain faithful to the original goals and purpose of the project.

The National Health Insurance program area is at the center of various risk-sharing approaches to health care coverage. Although an administrative transformation, the Devolution program area is key to resource allocation issues, and efficiency across the public sector, especially hospitals. Standards, Licensing, and Regulations and Public Resource Management also are germane to devolution and financial planning issues. The Health Policy Process program area is largely unchanged from the original design, and it remains a valid approach to building capacity in the Philippines.

The five new program areas are essentially parts of the original components that have been extracted from the previous range of activities and approaches. A strong argument can be made, and indeed was made, for these new areas of focus, but it is difficult to assess whether other possible areas of focus could be producing a greater impact on health financing problems. For example, some of the work on Devolution and Public Resource Management provided resources and assistance to carry out what the DOH had to do under any circumstances.

The concentration of project resources in these areas took away from other possibly larger impact areas, such as private hospitals. These hospitals have proliferated in the Philippines in the past two decades, and they provide about half of all hospital-based services. Yet, they have enormous problems with internal efficiency, and are adversely affected by various government policies. Providing the appropriate financial and policy incentives to private hospitals, as originally envisioned in HFDP, could greatly expand health care availability and quality at fairly low cost. Investment of project funds in the development and promotion of policies affecting private hospitals could have possibly produced greater returns in the health

sector than the use of these funds for supporting the preparation of DOH annual budget submissions.

At the time that the new program areas were conceived, the HFDP was widely dispersed, carrying out a range of activities. In fact, the evaluators have the impression that the Project was trying to do too much, and was covering too many issues to be effective. The re-casting of the Project into five technical areas, and the subsequent reductions in budget, served to focus the project and put it in a position to address fewer issues more adequately. Whereas some of the new technical program areas may be questioned, they do fit into the original project objectives, and they have made, or are likely to make, a contribution to improving the overall health financing environment.

### *Recommendations:*

The five technical program areas are appropriate to current needs and conditions and should remain unchanged for the life of the project.

## **3.2 Project Strategies**

*Are Project strategies appropriate to meet revised objectives, and what modifications, if any, are required?*

### **3.2.1 National Health Insurance (NHI)**

#### *Findings:*

This program area consists of two main parts. The first part aims to assist the DOH and Congress in developing feasible national health insurance proposals and plans. The second part is equivalent to Component 2 under the original project and relates to Medicare reforms and demonstration activities.

#### *a) National Health Insurance Proposals*

Universal health coverage through national insurance has been in the minds of policymakers for some time in the Philippines, and several bills to this effect have been presented in the past year. One of these bills resulted from an interaction in a HFDP-sponsored meeting in mid-1993 in which the DOH was requested (and agreed) to come up with a draft bill. A working group was formed under the leadership of the DOH comprised of DOH staff, a USAID staff member, and two MSH Advisors. This working group produced a draft bill by

December 1993 and it was submitted to the Senate in early 1994. Many people we interviewed thought the bill had a good chance of passing both houses of Congress in 1994. The bill calls for universal coverage by consolidating the present public insurance schemes and expanding the plan to the entire country. It proposes to reimburse for inpatient care, and emphasizes outpatient benefits, especially for preventive/promotive services, but it does not specify a variety of mechanisms required to implement such a scheme.

The HFDP performed a solid service by participating in many of the activities which were required to develop the bill. This included direct financial support for meetings and discussions, a two-country study tour for key participants, and technical assistance from MSH staff. In addition, Project researchers have carried out policy analyses of cost implications of various implementation approaches. Observers agreed that the HFDP played a key role in the bill preparation process.

This is an example of how a flexibly designed project can provide needed resources and technical expertise at a critical moment and positively affect a potentially landmark event in national health policy. The HFDP strategy of promoting improvements in public health insurance through the provision of technical and financial assistance was effective and appropriate.

#### *b) Medicare Reforms*

The Philippine Medicare programs (consisting of GSIS, SSS, and EC) had two critical deficiencies when the HFDP was conceptualized. First, their administrative, financial, planning and evaluation functions were not adequate to the task of managing large insurance programs from the operational, strategic, and policy perspectives. This has resulted in numerous inefficiencies, and limits the administrative capability to expand. Second, Medicare had a less than successful record at extending coverage to those not enrolled under formal sector employers. In effect, 60 to 80 percent of the population were not covered by Medicare programs.

The Medicare reforms component of the HFDP took on much greater significance as NHI emerged as a real possibility in 1993. Virtually all of the findings, recommendations and subsequent administrative and policy improvements emanating from HFDP work would now be not only relevant to the existing programs, but would become central to the design of the new national insurance scheme. In fact, no matter what legislation is adopted, the Medicare and other demonstration projects, and technical assistance activities are critical to the viability of design of any new NHI plan.

With respect to the administrative reforms activities, the Project has completed three studies (claims processing, compliance, Medicare reorganization) analyzing the problems and issues, and suggesting recommendations for improvements. It has also sponsored several working groups to address key Medicare problems (fraud and abuse synergy committees, etc.) These completed activities have only reached the study and discussion stage. The findings and

recommendations apparently have not yet been formally presented to Medicare or participating program managers for action. The need for most of these studies were known and specified before the Project was initiated in 1992. Yet several studies are still pending (RUV scale development and peso computation values, MIS, IE&C plan) and several have been dropped because of financial and time constraints. More efficient implementation of these planned studies would have left a more comprehensive legacy for the Project in the area of Medicare reforms.

After two years, the HFDP has initiated one full-scale demonstration activity in provincial health insurance. This is the Bukidnon Health Insurance Project which was started in February 1994 with service delivery to begin in June 1994. The demonstration is being carried out by the Provincial government and PMCC staff with technical and financial assistance from the HFDP. Other assistance activities have occurred with the Quezon P-2 Medicare Expansion Program, and in initiating provincial health insurance schemes in Guimaras and Tarlac. The latter two efforts are mainly short-term consultancies to assist with MIS and financial systems. The Project also explored the possibility of testing employer-based insurance schemes. Finally, the Project followed up on an activity begun before HFDP's start to test the feasibility of benefits expansion through Medicare to include in- and out-patient services in urban areas.

As with the administrative reforms above, the need for these demonstration projects were known before HFDP began. Yet, the project has made inexcusably slow progress. Section 4.1 discusses the apparent causes of slow implementation of the demonstrations.

Delays in implementation coupled with HFDP's cutbacks have compromised the potential effectiveness of the Medicare demonstrations. Their expected contributions to the implementation of NHI are similarly compromised by the lack of progress. For the few remaining demonstration insurance activities, there may simply be not enough time or staff resources to follow-up on what needs to be accomplished to evaluate the efforts. As noted, the centerpiece Bukidnon activity has just started delivering services in June of 1994. It has only 4,000 enrolled members against the expected 10,000 plus, so the scheme is not "up and running" at its designed level. The MSH contract supporting this activity will terminate in September 1995. Thus, there are only 14 months of project assistance currently remaining for Bukidnon. Given the history of the project, it is unlikely that this is sufficient time to carry out baseline studies, diagnose and correct problems, and evaluate its financial, administrative, management viability. Further, it is probably not enough time to evaluate central aspects of the program, such as services utilization and provider behavior.

The same comments can be applied to the Quezon P-2 Medicare Project. Thus, there is some likelihood that these important demonstration projects (Bukidnon and Quezon P-2) will be without the financial and technical resources for required modifications and evaluations at the time that they would be mature enough to make the findings meaningful.

A full-scale demonstration activity is currently planned with Philamcare to test benefits expansion for in- and out patient services. This effort was approved in principle by the PMCC Board of Directors in late 1992. The HFDP initiated the design of this activity in the Fall of 1993. The design study was still underway at the time of this evaluation, and is not expected to be completed until September 1994. This would mean that the actual start-up of this demonstration activity would not begin until the Fall of 1994, at the earliest. By this time, there will be only 8-10 months remaining in the HFDP at most. It is questionable what can be learned in this amount of time, and it is unknown what financial support will be available after HFDP is terminated in 1995 for the kinds of evaluation required (currently the Project has \$180,000 slated for evaluating Bukidnon, Quezon, and Philamcare).

Despite the lengthy amounts of time spent on design and decision making in these demonstration activities, it appears that some technical issues remain that need to be addressed in the remaining 14 months of the project. These involve pricing, costs and containment measures, means testing, drug sales by medical providers, types of services offered, and the role and need for reinsurance. One key issue to illustrate these technical questions involves outpatient services in the Bukidnon Program.

Outpatient benefits have taken on more importance as the NHI bill supported by the HFDP calls for coverage for personal outpatient services, and preventive/promotive care. The concern for outpatient and preventive care exhibited in the Senate NHI bill is well-founded. A large portion of hospital admissions occur through illnesses or events that could be prevented (e.g., pregnancies), or could be treated at earlier stages before hospitalization (tuberculosis, acute respiratory infections, etc.). Thus, adequate outpatient care not only has a potential impact on overall financing, but it directly affects the health status of the population. Project managers stated that preventive/promotive services would be availed of by clients through the public sector. But this approach assumes that the public system can and is providing universal coverage for these services such as immunizations and family planning.

Other capitated insurance programs have shown that outpatient services need to be carefully managed by controlling treatment protocols, educating providers and consumers, targeting high-risk members, and offering an effective mix of services. The documents provided the evaluators on Bukidnon were limited, and the requested operations manual was not furnished. However, it appears from what the evaluators did see that these outpatient issues are not addressed in the demonstration project. For example, doctors do not have specified treatment protocols, they have not had much in the way of orientation to capitated systems, and they are not trained, for example, to check all children for immunizations and refer those needing them to the public system.

In short, the doctors appear to have become providers of curative outpatient and inpatient care along the lines of current fee-for-service practices. (There was a reported doctor's "uprising" in Bukidnon during the evaluation specifically related to these issues.) These

issues are critical because if they are not handled correctly, they can affect the viability of the demonstration as the Bukidnon doctors may already have realized.

### *Conclusions:*

The HFDP provided essential assistance to the process of developing the Senate's National Health Insurance bill. There is a good chance that some version of this bill will be adopted by the Congress. The project can play an equally important role in the actual design of the national insurance program (through the to-be-determined Implementing Rules and Regulations, and through its work on estimating the costs of alternative plans) if the bill is passed in the next 6-8 months.

The project has helped Medicare set the stage for major, positive reforms in administration by supporting studies on claims processing, compliance, and structural organization. In addition, persons interviewed stated that operational improvements, such as linking up hospitals and eligibility records and SSS, are on the verge of being tested. Other potential operational improvements have been stimulated by the Project's support and participation in "synergy committees" aimed at addressing efficiency problems in the public insurance systems.

The HFDP staff have worked closely with PMCC staff on operational issues, on the improvement of Medicare II experimental programs, and on the Bukidnon Health Insurance Project. There is a consensus that these working relations have improved the capacity of the PMCC to manage its operations, design and evaluate insurance expansion activities, and train provincial and other LGU counterparts.

All observers agreed that while essential groundwork has been done on administrative reforms, the findings and recommendations now need to be operationalized to improve efficiency in existing public health insurance programs. To achieve operationalization, the findings and recommendations of the studies need to be distilled and conveyed to the PMCC Board of Directors and to the managers of the component agencies (GSIS, SSS, ECC) in such a way that they are motivated to implement the reforms. This will require concisely and convincingly written policy briefs, careful policy dialogue activities, and probably the offer of follow-up assistance.

The demonstration activities in Bukidnon and with Philamcare have taken longer to develop than anticipated at the Project's outset. It is doubtful that Bukidnon will be adequately evaluated by September 1995, and that the Philamcare improved benefits demonstration activity can do any more that just get started by the same time. With only fourteen months remaining for HFDP technical assistance, continuation of this activity will depend on the viability of the design and the ability of PMCC staff to manage it past September 1995.

Large amounts of technical assistance will be needed for Bukidnon, Quezon, and Philamcare, and lesser amounts for Guimaras and Tarlac. There are various important technical issues that will need to be resolved in the Bukidnon Project, for example, as it develops in the next year. This technical assistance needs to be provided through the project's remaining funds.

HFDP needs to pay more attention to the health status implications of the various financing schemes. There is virtually no explicit connection made between health financing activities and health outcomes in any HFDP's documents consulted for this evaluation. This relationship is to a great extent embodied in the types of services and advice offered, treatment protocols, referrals, physician knowledge and incentives, preventive orientation, prescription practices, etc., for outpatient care. All of these have a large impact on health financing. This relationship is well understood by insurance programs around the world, for example, which routinely reimburse or refer for immunizations, family planning, stop-smoking treatments, and even exercise programs among others. Well-conceived efforts to manage health status and service mix are not seen in the demonstration activities.

The area of outpatient benefits is a place where the HFDP can show how its activities can have a positive impact on basic health status of the beneficiary population, and make a contribution to the achievement of national health goals.

For Bukidnon, Quezon, and Philamcare, rigorous evaluations need to be planned, for without them it will be difficult to judge key aspects of these demonstrations and to apply the lesson to future Medicare expansion or NHI.

### *Recommendations:*

1. The HFDP should continue to work with the DOH on its efforts to support a viable National Health Insurance bill. If a NHI bill is passed by Congress, the Project should provide as much technical and financial resources as it can to assist in the development of the Implementing Rules and Regulations (IR&R). The work done by the HFDP on costs of NHI alternatives should be pursued and incorporated into the IR&R that will determine the structure of the plan.
2. The Project should make a concerted and immediate effort to compile the findings and recommendations from its work in Medicare administrative reforms. These should be presented to and discussed with the directing managers of the PMCC and member agencies with the objective of stimulating operationalization of the proposed reforms.
3. The Project should press ahead with its plans to assess the on-going Bukidnon experiment. An intended baseline survey should be implemented, and experts should be brought in to examine key technical issues surrounding this activity. Key technical areas need to be monitored closely and modified as necessary.

4. Bukidnon's outpatient component needs to be strengthened to include an effective orientation program for participating physicians and providers. This would include emphasis of the value of preventive and promotive care such as immunizations, family planning, and early treatment of common illnesses. Physicians should have a simple manual that would provide guidance on treatment protocols and referral procedures. Explicit linkages with the public sector should be specified especially for outpatient services.
5. Implementation issues for rigorous monitoring include pricing, utilization control, means testing, drug sales by medical providers, types of services offered, and level of provincial subsidies (i.e. costs). It is to the benefit of the client, the doctor, and the financial viability of the insurance program, for example, if the treating physician screens children for immunizations and refers those with incomplete series to the nearest public facility. Similarly, women with unmet family planning needs should be screened and directed to the appropriate service provider. These linkages are most effective when the physician provides referral slips, knows what facilities offer these services, knows their hours of operation, and follows up on referrals on a regular basis.
6. In addition to the baseline and the on-going assessments mentioned above, the Project should design an evaluation to take place in July-September 1996 after the activity has operated for two years. Funding for this evaluation will be needed in the final year of HFDP.
7. Similar assessment and evaluation plans should be carried out for Quezon P-2.
8. The DOH, PMCC, USAID and HFDP staff should carefully assess what can be accomplished with the Bukidnon, Quezon, and Philamcare demonstration activities in the time remaining under the existing contract.
9. Before September 1995, the HFDP should prepare a summary technical analysis of the findings of the insurance demonstration activities including recommendations and suggested action plans for FY96.

### 3.2.2 DEVOLUTION

#### *Findings:*

The Local Government Code of 1991 caused enormous changes in the organization and management of public health services in the Philippines. Nearly all administrative, financial, management, and programmatic functions previously carried out by the DOH were transferred to Local Government Units (LGUs). In one act, the role and function of the

DOH were transformed, and the LGUs were now in charge of their own operations. The DOH retained 45 hospitals, and maintained responsibility for some key public and primary health programs. By 1993, the DOH had resolved that it would provide all the support it could muster to assist in the devolution process especially in the areas of new policy, operational, and organizational directions.

To accomplish its goal, the DOH organized a Task Force on Devolution (and later a Management Committee on Devolution) to prepare a devolution strategy and develop the required implementation policies. The HFDP assisted these working groups by sponsoring seminars and workshops and agreed to provide assistance in several key areas.

A most critical area of concern in devolution is how to maintain health service priorities and standards in the LGUs now that they have full responsibility for the program. To address this issue, the DOH and the HFDP developed a Comprehensive Health Care Agreement (CHCA) through which DOH technical assistance and funding for special programs would be provided to LGUs in return for guarantees of fiscal and management responsibility, and the continued implementation of priority health programs. The prototype agreement and operational guidelines were commissioned by the project. By the time of this evaluation, CHCAs had been concluded with the majority of LGUs in the country. This is a major positive step forward in the devolution process.

The Project is also carrying out other technical activities to help the DOH operationalize the devolution strategy. These include an examination of funds flow mechanisms at the LGU level, an analysis of DOH Integrated Field Health Offices to include operational guidelines (and possibly a pilot project), and an analysis of the implications of the Magna Carta for Health Workers. At the time of the evaluation, these activities were either completed or near completion.

Other studies and technical assistance were undertaken by the HFDP related to devolution financing issues. A study is underway to examine the determinants of LGU fiscal behavior, and to suggest policy tools that could be used to influence resource allocations. In addition, the Project undertook the design of a training course for LGU managers which would cover the various issues surrounding the administration of devolved health operations.

A final area of importance in the process of devolution involves hospital operations. Nearly 600 public hospitals were turned over to LGUs. These devolved hospitals face numerous problems as a result. Their budgets have been trimmed, facilities are deteriorating quickly, and devolved staff have little experience in management and planning. Little is known about what management and ownership options are feasible for LGUs wishing to divest or restructure hospital operations in the new environment of local administration of publicly operated health services.

To address these needs, the Project prepared a manual on the organizational options for devolved hospitals. This is an easy guide to follow which clearly lays out the types of

hospital ownership and management options available to LGUs. The guide is targeted to hospital managers and provincial administrators. Included in the manual is a shorter policy brief that appears to be aimed at higher level policymakers. Observers agreed that this manual was an essential and valuable tool, and that it would fill a major need by LGUs in solving hospital administration issues in the next several years.

The issue of devolution is intimately linked to the DOH strategy for the entire hospital sector. Thus, the HFDP became involved not only in administrative and management issues surrounding the devolution of hospitals to LGUs, but also with issues pertaining to retained hospitals. Through the Standards, Licensing and Regulations program area the project became involved with DOH and Government policies affecting private hospitals. The project therefore, also carried out various activities (some of which are noted under Section 3.4) to assist the DOH in developing more efficient management of the retained hospitals, examined policy incentives affecting private hospitals, and worked effectively on improving the strategic planning capacity of hospital policymakers and managers at the central and provincial levels. In addition, the Project supported the DOH's interest in expanding its preventive/promotional services through its retained hospitals, and started a promising pilot test of a computerized hospital management information system.

The HFDP has prepared a summary of findings, issues and recommendations related to devolution of hospitals, retained hospitals, and private hospitals.<sup>1</sup> This is the only such document of its type encountered by the evaluators, and it serves as a model on how Project work can be synthesized into brief, readable documents that capture the findings of diverse studies and summarize recommendations for policymakers.

### *Conclusions:*

The challenges of devolution are enormous for the DOH and for LGUs, and any government agency would be hard pressed to handle such a transformation in a short time. The DOH has made considerable progress in facilitating the process of devolution, and it has been helped in considerable measure by the HFDP through its technical inputs, support for policy dialogue, and sponsorship of essential devolution tools.

In particular, the HFDP has done a good job at developing a highly effective protocol document governing the relationships between the DOH and the LGUs, i.e., the CHCA. The use of this document has smoothed the transition to devolution, helped define the roles of the DOH and LGU, and guaranteed continuity in program priorities.

---

<sup>1</sup> Nañagas, Juan R., Romeo M. Cruz, and George P. Purvis. 1994. "The Management of Philippine Hospital Services Post Devolution: Concepts, Strategies and Recommendations. Draft Paper, Health Finance and Development Project, Manila. June.

Other analyses and studies can lead to policy tools to assist in the process of devolution in the areas of financial resource allocation, funds flows, management, and training programs.

The HFDP has carried out some excellent ground work that will help ease the devolution of hospitals. These contributions include sponsoring various working sessions with DOH and hospital personnel to identify issues and develop strategies and preparing ownership options for devolved hospitals and operational manuals for devolved and retained hospitals.

### *Recommendations:*

1. No alterations in the current HFDP strategy on devolution are suggested. However, when the current studies and analyses on devolution being carried out by UPecon are completed, the HFDP should synthesize the findings and recommendations into a summary and a policy brief. Project managers may want to consider how to present the findings and recommendations in ways that can provide operational guidelines for devolution processes.
2. The considerable work on hospitals has been synthesized and summarized. This document should be disseminated as completely as possible. In addition, the Project should identify a mechanism through which the Manual on Ownership/Management Options can be made available over the next several years as the need for this guidance grows at the provincial level.

### **3.2.3 Public Resource Management**

#### *Findings:*

This focus area was not originally featured in the HFDP, however, the incoming Administration assigned considerable importance to it and succeeded in moving it to be a main focus of the revised Project. The Public Resource Management area pertains mainly to the budgeting, planning, and investment activities in the DOH. With devolution, these functions changed as the DOH's role shifted in the public health system.

The Project worked closely with the Internal Planning Service (IPS) of the DOH to effect improvements in annual budget preparations, authorizations, and accountability. It provided expert consultants, sponsored seminars and training sessions, paid for technical positions in the DOH, and provided feedback to various budgeting exercises. One observer in the DOH noted that the technical and financial inputs of the HFDP were instrumental in the successful preparation of the 1994 and 1995 budgets.

Besides budgeting, the Project supported two potentially important planning exercises. It sponsored the development of medium and long term national health plans that are designed to provide a blueprint for the next 25-years. This exercise is a highly collaborative process involving meetings and discussions with various groups around the country to obtain regional inputs, and to build a consensus. This process will continue through 1994. Activities to develop these plans are carried on through a National Health Plan Secretariat in the DOH, and the HFDP has funded the operation of this office during its existence.

Another key activity in the Public Resource Management area was the development of a 10-Year Investment Plan. Working with the DOH, the Project developed a logical plan for investments given the country's health needs in the next decade. This had never been done before, and its existence now gives the DOH not only a rational investment plan, but it also provides DOH managers with a strong policy tool with which to defend budget requests. It also has the great advantage of linking up programs to expected expenditures which in turn will provide much needed overall guidance to the annual budgeting process. The 10-Year Investment Plan has been presented to the National Economic Development Authority where it met with the approval of this important agency. A consensus-building approach was also undertaken in the development of this plan, including sensitization meetings with NEDA before the official presentation.

Associated with the 10-Year Investment Plan is the proposed development of a National Health Facilities Enhancement Plan. This is a modest, but potentially significant effort, to develop a solid DOH position on its needs to improve its hospital and clinical infrastructure which appears to be deteriorating rapidly with budget cutbacks and devolution.

### *Conclusions:*

Before the HFDP began to provide assistance, the DOH budgeting process was largely additive whereby incremental amounts would be added to line items year after year. After a while, this kind of budgeting obscures the relationship between actual budget allocations and health priorities. The work that the HFDP has done with the IPS represents a solid step in the direction of rationalizing the budgeting process in the DOH. The processes involved in accomplishing these improvements have helped install a better financial planning capacity, better program costing ability, and better budget projection skills among staff.

The Project appears to have provided a major impetus to re-orienting IPS from a field operations planning office to a strategic health sector planning group. This reorientation is essential for the DOH to play the fiscal leadership role it must under devolution.

The development of the National Health Plan is a needed document which can have a positive impact on devolution and the future of the health sector in the Philippines. The HFDP is playing an important role in supporting the preparation of this plan including

technical inputs. However, it is unknown what the prospects are for having the National Health Plan adopted or implemented.

The HFDP has supported the preparation of a 10-Year Investment Plan that can be instrumental in setting priorities and shaping resource allocations over the next decade. This type of planning needs to be institutionalized at the DOH and in the minds of other agencies, as well as the Congress, who are central to the DOH's budget levels.

### *Recommendations:*

1. Project managers should explore how a consensus can continue to be built around the 10-Year Health Plan, the National Health Plan, and the National Health Facilities Enhancement Plan. This would undoubtedly include further dissemination and policy dialogue activities, and the preparation of easy-to-read and understand policy briefs or summaries of the Plans that can be used with policymakers and the media. In addition, it will be important to undertake activities that assure that DOH and LGU senior staff buy into these Plans.
2. HFDP managers will need to weigh the value of providing direct financial and technical support to the IPS in light of other demands for remaining project funds especially after September 1995.

### **3.2.4 STANDARDS, LICENSING AND REGULATION**

#### *Findings:*

Health Devolution resulted in the DOH losing direct control over service delivery and the majority of medical facilities and associated personnel. Despite the loss of control, the DOH still has the responsibility to maintain minimal standards of health care, to influence program priorities, to provide technical guidance in operational and administrative matters, provide leadership in fiscal policy, and regulate the sector in a variety of ways. To meet these increased needs for regulation and oversight, the DOH in 1993 sought to strengthen its capacities in these areas. The Standards, Licensing and Regulation (SLR) program, therefore, became a focus area for the HFDP.

HFDP is providing the DOH assistance along three lines under this program area. First, it is preparing a series of recommendations for improved strategic planning and financial management for retained hospitals. Second, the Project is suggesting and testing improvements in hospital operations. Finally, it is providing assistance to strengthen the basic standards, licensing and regulatory function in the DOH.

Several observers pointed out that at the beginning of the HFDP, there was little interest on the part of DOH and others in working on hospital-related issues. Initial activities of the Project included a study of retained hospitals, a study of devolved hospitals (mentioned above), the development of a strategic planning workbook for hospital managers, and an effort to strengthen the preventive/promotive primary health care functions of retained hospitals. As the devolution process progressed, the importance of the SLR function became more apparent to the DOH and more emphasis was placed on this area as the HFDP was re-cast into its current form.

The project has done considerable work in building up the strategic planning capacity of the DOH, the retained hospital directors, and to a certain extent private hospital managers. This work seems to have been effective as DOH staff now speak knowledgeably about management options, the need to manage retained hospitals as a network, the need for information systems, and the need for sound financial management. At a minimum, this process has laid the foundation for hospital improvements based upon a better planning process. Similar work was carried out with the Philippine Hospital Association Board of Directors and select regional memberships.

Financial sustainability is perhaps the most pressing problem facing public hospitals today (both retained and devolved). The HFDP with the DOH is testing ways to improve cost recovery in hospitals, and to raise the quality of services by retaining a portion of the revenues for direct local expenditures. Two revenue enhancement demonstrations are underway; however, there are some implementation problems cropping up mainly due to the lack of Implementing Rules and Regulations.

Besides cost recovery, the Project has tackled several other major operational issues. It has initiated a program to strengthen the preventive/promotive capacity at 12 of the 45 retained hospitals. This program has been judged a success in making hospitals friendlier, more caring places for clients to visit, and in having them pay attention to primary health needs. Since people often bypass primary care facilities and go directly to hospitals for even minor complaints, this may be a reasonable strategy to adopt until such time that the incentives for this client behavior are altered.

The Project has assisted the DOH in publishing ten Hospital and Technical Manuals. These manuals had been in draft form and considerable effort was invested to edit and publish them in the proper format. The manuals will be distributed to the retained hospitals, and possibly to the devolved and private hospitals. Their effectiveness would be greatly enhanced if they were distributed during training sessions explaining them. Beside these manuals, the Project has sponsored an effort to establish a computerized hospital operations system in retained hospitals.

Arguably the most important activity in this program area is building the capacity of the DOH to carry out its SLR function effectively and efficiently. Little appears to have been done in this area other than the hospital operating manuals mentioned above. Two other

activities are scheduled for completion this year that would presumably result in recommendations for a SLR strategic plan; an organizational structure, and operational guidelines for carrying out the SLR function in the field.

### *Conclusions:*

Given the problems in the hospital sector, and the complications of the standards, licensing and regulation function, HFDP and the DOH had literally scores of possibilities for activities. The Project was channeled to address issues of more immediate concern to the DOH in this program area. Broader, potentially more important policy issues may have not been addressed for this reason. For example, while much attention is paid to existing hospital operations, there is little cover given to the structure of the hospital sector itself. Structural problems, e.g., existing demand incentives, distribution, public-private competition, availability of capital, etc., could be just as, or more, important than solving short-term operational obstacles. Despite this "channeling", the project was able to accomplish a considerable amount, especially given that only one HFDP staff member provided technical leadership in this areas.

Addressing the issue of revenue retention and starting experimental projects could have a long lasting positive effect on the financial sustainability and the quality of care in public hospitals. The revenue enhancement demonstrations need to be monitored closely, modified as required, documented, and thoroughly evaluated.

Judging by the documentation produced, the Project has performed an invaluable service in orienting managers toward strategic planning, and improving their strategic planning skills through participatory exercises. It is safe to say that DOH personnel and retained hospital directors have a much clearer sense of administrative, financial and management issues (and how to address them) than they would have had in the absence of the HFDP.

The work done on retained hospitals i.e., strategic planning manual and techniques contained therein, is largely applicable to the devolved hospitals as well. Similarly, the efforts to improve the preventive/promotive capacity of hospitals could be applicable to devolved hospitals.

Work has proceeded slowly on establishing a strengthened SLR function at the DOH. Several key activities which would provide a foundation for better SLR organization and operation are in place and are scheduled to be completed in 1994.

However, current HFDP plans for assisting in building the SLR capacity at the DOH extend only to helping the DOH develop a conceptual and organizational framework. It is doubtful that the project can do any more given that there are only fourteen months remaining and this activity is just getting started.

### *Recommendations:*

1. The list of remaining activities is long in this program area. Project managers should review the activities and resources available to insure they have staff and resources to carry out the planned activities.
2. The revenue enhancement demonstration activities need to be thoroughly monitored, modified as needed, and evaluated. If an adequate evaluation is not possible in the next fourteen months, plans should be made to evaluate the demonstrations using funds remaining in the project in FY 96. Policy briefs and summaries should be circulated widely, especially to devolved hospital directors, if these activities are successful.
3. Strategic planning materials should be disseminated more broadly. The planning materials (strategic planning manual, etc.) should be prepared for distribution to the directors and managers of devolved hospitals.
4. Follow-up assistance to build SLR capacity should be sought from other donors.

### **3.2.5 Health Policy Process**

#### *Findings:*

This program area is essentially Component 1 under the original project design. The objective of this component was to strengthen and institutionalize a health care policy process in both the public and private sectors. The end-of-project status was to be an integrated set of policies and strengthened capacity that would eventually lead to a positive restructuring of health financing in the Philippines.

At the outset of Project activities in this area, there was a limited information base upon which to build a health financing policy process. In addition, there were few scholars and policy analysts in any discipline who devoted themselves to the study of Philippine health financing issues. Therefore, the Project managers focused in the first year-and-a-half on expanding the knowledge base, disseminating findings and recommendations, and setting up short- and long-term training programs. This course of action not only followed the "ideal" approach outlined in the project paper, but it also was consistent with UPecon's cooperative agreement that called for generic research and a strengthening of academic training in health financing.

In the first year-and-a-half of the Upecon cooperative agreement and the first year of the MSH contract, more than thirty papers were published on health policy issues by a variety of

authors. Several of these are essential basic documents for understanding the health sector in the Philippines and have been widely disseminated. Among these papers were also analyses of what should be health policy priorities, and what agenda should govern the HFDP's research activities.

Studies were also begun analyzing available data sets that could be used for health policy analysis. By September 1993, twenty such data set analyses had been carried out along with an additional eleven research papers. The Project also set up its long-term training plans, and selected and enrolled graduate students and expanded the offerings at UP in health economics and related courses. In addition, the Project began to respond to DOH requests for assistance in the Devolution area. It also began the process of supporting the staff and activities of the Health Policy Development Staff (HPDS) and the Department Legislative Liaison Office (DLLO), and of establishing the Multisectoral Health Policy Forum which was to assure private participation in the health policy process.

By the Fall of 1993, several key issues were emerging as critical health policy areas as a result of the Project's previous analytic work, e.g., national health accounts, budgeting, cost recovery, LGU financing, etc. In addition, the DOH was beginning to focus on its priorities as it faced devolution and possible reorganization under its new mandates.

The re-focusing of the Project in October-November 1993 resulted in a concentration of the Health Policy Process program area into six parts. The first part was to strengthen the HPDS and the DLLO in the Department of Health. These offices were to be coordinators of internal policies and of proposed legislative policies. They would theoretically provide technical inputs and manage the operational aspects of policy development at DOH and with Congress. The Project has provided short-term training to most of the staff at HPDS, furnished a variety of consultants, and has financed virtually the entire operation of the DLLO and one HPDS contractual staff person. In addition, the former director of the HPDS was sent to the U.S. for graduate training in health financing and has recently returned to the DOH. Not much has occurred in the way of collaborative research, policy analysis, or operational coordination between HPDS and UPEcon or MSH. This phenomenon is explained differently by the respective staffs.

The second part, developing a National Health Accounts (NHA) Database, has proceeded apace at UPEcon over the past year. The work is scheduled to be completed in the Fall of 1994. By this time, a complete system should be in place for tracking expenditures by program areas. The existence of this tool will give the DOH a tremendous advantage in its budgeting process, analyzing the impacts of current policies, evaluating programmatic decisions and policies, examining health insurance cost issues, and in negotiating with donors. The main issue with this part of the program area is the extent to which the National Statistics Office (NSO) can institutionalize the NHA data collection process, and who will continue with the analysis of the database that needs to be done each year for this to be an effective tool for the DOH.

The third part of the Health Policy Process focus area is the Multisectoral Health Policy Forum. This Forum lost some of its importance as expanding the role of the private sector in the health sector lost its preeminent position in the HFDP under the new DOH administration. The process of establishing an independent Forum has been more bureaucratically difficult than originally envisioned, and time has been lost for this reason. However, three meetings have been held to date. The discussions in these meetings have focussed on the proposed NHI bills and taxation issues in the health sector. These meetings have reportedly had little impact on the health policy process. Nevertheless, it is the only Forum of its kind in the Philippines, and it is one of the few mechanisms available for private sector groups to make their views known to the Government and the Congress.

The fourth part pertains to monitoring policy development, conducting health sector policy reviews, and compiling a health policy database. Work have been undertaken in each of this areas. HPDS has developed procedures for policy formulation and responses to Congressional inquiries. Health sector policy reviews have been completed with MSH assistance. Work is on-going on the UPecon benchmark of developing a computerized health policy database.

The last two parts involve supporting the reorganization of the DOH, continued general training in health financing policy, and the continued publication and dissemination of project outputs. The project commissioned a study on the reorganization of the DOH, but no action has been taken on the recommendations which is probably beyond the purview of the project.

### *Conclusions:*

Much research and policy analysis work has been done under the Project. Some of these papers, agendas, and analyses have had important impacts on health policy development in general and on the HFD Project activities, in particular. Others seemingly have hardly been noticed. In any case, a great deal of useful research work done under the Project is or will be of benefit to the health policy process.

Some level of institution building has occurred in developing the staffs of the HPDS and DLLO although not to the degree desired by the DOH. However, the DOH has yet to assign fully official status to the HPDS office, and has not yet filled the total number of positions originally envisioned for the office. The DOH has allocated 2 million pesos for the support of the office in the 1995 budget, so there may be some emerging appreciation among senior DOH management of the value of such an office. This question is relevant to the sustainability of the health policy process capacity in the DOH.

The development of the National Health Accounts is a key aspect of improving health financing in the Philippines. The Project is to be commended for undertaking this task and for being on the track of completing it successfully. However, the methodologies and the data are only useful in the future if it becomes an institutionalized process, if it is analyzed,

and if it finds its way into the hands of public and private sector managers and policymakers. At present, it is not known what provisions are in place to assure that the data collection and analysis will take place on a timely basis past after the completion of the HFDP.

The Multisectoral Health Forum is one of the few places that the private sector voice is explicitly heard in the Philippine health policy process. This Forum is just getting off the ground, and has yet to have the kind of impact that was anticipated as the project was designed. The project is seeking a permanent home for the Forum after September 1995.

Training in health policy matters has been an important contribution of the HFDP. DOH staff have been exposed to short courses on health financing and health economics, legislative fellows have been appointed to the DLLO, graduate students have been attracted to study health policy and financing, university scholars and analysts who otherwise would not have begun contributing to the health policy literature, local persons have been sent on long-term training in the U.S., and local research groups have improved their capacity to carry out health policy research and analysis and to provide technical assistance. Thus, the "market" for health policy development and analysis is much more substantial than it would have been without the HFDP.

HPDS indicated that while it greatly appreciated all of the training and research carried out under this program area, it would like to have more input into what kind of research is being carried out, and who is being trained.

### *Recommendations:*

1. To the extent feasible, over the next fourteen months research and policy analysis findings and recommendations need to be synthesized and discussed with health policymakers. At a minimum, an annotated bibliography should be prepared of project outputs which can be widely circulated in the DOH, the private sector and the research community. Dissemination activities should be worked out jointly with the HPDS.
2. HFDP managers should strive to reach more concrete agreement on the institutionalization of the National Health Accounts.
3. An effort should be made to find a permanent home and sponsorship for the Multisectoral Health Policy Forum in the next fourteen months. Perhaps, the effectiveness of this group and its visibility could be enhanced through the issuance of position papers if agreement on principles can be reached by the members.

### 3.3 Changes in Project Environment

*What were the effects of external and unanticipated actions and/or events on the Project, such as changes in DOH leadership, administration, and priorities; enactment and implementation of the Local Government Code and the Magna Carta for Health Workers; and the reduction in the level of USAID resources? In lights of these changes, what modifications are necessary to achieve revised objectives?*

#### *Findings:*

Since the signing of the project in September 1991, the environment in which HFDP has been implemented has been nothing short of tumultuous. However, two major events which occurred in this period - the Local Government Code (LGC) and the change in national government administrations in 1992 - were certainly not unexpected, though the exact ramifications of these events could not be fully predicted in advance. The LGC was signed into law in 1991 and the 1992 Presidential elections followed the Philippine Constitution and the election cycle. Therefore, HFDP's response to these two major changes are better viewed as adjustments to anticipated changes in the political and institutional environment of the project.

HFDP was designed under the Bengzon Administration and initially implemented under the interim Periquet Administration. Both of these administrations were keenly interested in HFDP. HFDP was enthusiastically supported by senior management in the Bengzon Administration. The Secretary and several key appointees came from the private sector and had managed private sector health organizations. The concept of establishing a policy environment that would stimulate private sector investment in the development of health care programs was seen by these individuals as essential for addressing the country's health care financing problems. Akin to the USAID-funded Child Survival Program, the design of HFDP was a joint undertaking between the DOH and USAID where the sense of ownership of the project was clearly established in the thinking of DOH officials.

After the 1992 election of President Ramos, Secretary Juan Flavio Velasco was selected to head the DOH. Throughout the remainder of 1992 and into 1993, the priorities and direction of the DOH were unclear and, when at times appeared to be clarifying, would change yet again. What was very apparent was that the new DOH Administration was far more "campaign" oriented than its predecessors. Several highly visible, action-oriented undertakings, such as the National Immunization campaign and the AIDS rally, were mounted in succession. Unquestionably, giving visibility to important public health issues is a very important role for the Secretary and the DOH. It also provided tangible evidence of the Ramos Administration's efforts to help improve the well being of the average Filipino, generating much needed credibility and support among the general public.

As the priorities and direction of the Flavier Administration took shape, the previous enthusiasm for HFDP dissipated rapidly. The project was gradually viewed as out of line with the prevailing interests of the Department. The longer-term pay-offs of the research-based policy formulation process and hospital finance reforms, in general, did not seem to mesh with the more immediate, day-to-day concerns of the DOH. Health finance was simply not understood or seen as a priority concern of the Department. In part, this reflected the relative lack of understanding about health care finance and what HFDP was about and could do among the people coming into office. In time, however, better understanding of HFC issues by these people reversed their initial antipathy toward the project. A HFDP-funded study tour to the U.S. involving key actors in the DOH, legislature and other health-related organizations contributed significantly to this education process.

With the entry of new DOH senior management, some of whom were unfamiliar with the bureaucratic aspects of donor assistance, demands for use of HFDP resources for activities outside of the on-going agenda of the project increased. Again, USAID made efforts to explain the limits imposed by project agreements and other official bilateral arrangements. This eliminated some of the more far-afield requests for assistance from HFDP. USAID tried to be responsive where possible, as well as provided guidance and assistance about using other resources, some of which were within the DOH's own budget, to meet Department interests. However, the prevailing view of DOH management continues to be that project resources should be tailored to support the current, immediate needs of the Department where possible. This is reflected in the value DOH managers now attribute to HFDP, i.e., activities which support current, day-to-day functions of the Department which pertain to underlying HCF issues.

Perhaps the least understood or appreciated aspect of HFDP by new DOH managers was its fundamental objective of developing the capacity for policy formulation and the establishment of a policy environment to stimulate private sector investment in health which would, in turn, contribute to meeting an increasing share of the country's HCF requirements through non-government channels. This situation is partially attributable to the fact that top DOH leadership came from a community based, public health background with little direct experience with private sector approaches to meeting HCF requirements.

The DOH itself confronted tremendous changes in its own responsibilities due to enactment of: a) the Local Government Code (LGC) and the devolution of health services and facilities below the regional level, and b) the Magna Carta which guaranteed enhanced benefits for all health workers in the country. The challenges the Flavier administration faced on assuming office were magnified by the pervasive resistance to devolution by health workers, on the one hand, and their expectations of improved working conditions and benefits, on the other.

The LGC complicated this situation further by making the local governments now responsible for complying with the Magna Carta at the very time they lacked adequate resources to maintain existing health services, payrolls and benefits. Though the DOH was no longer responsible for personnel and services from the Provincial level on down, it was responsible

for assuring that the conditions specified in the Magna Carta were met. Understandably, the DOH placed priority on using project resources to help it respond to these massive changes.

Devolution presented both challenges and opportunities to HFDP. The challenge was to provide assistance to DOH so that it could respond credibly to the fundamental changes in the provision and management of public health services, but to do so within the objectives of the project. At the same time, devolution presented a major opportunity for HFDP to orient its HCF work toward immediate DOH operations in ways which advanced project objectives. Much to the credit of the project, it was able to provide very useful assistance to the DOH. Work specifically addressing the devolution process, such as the development of Comprehensive Health Care Agreements, as well as factoring in changes resulting from devolution into HFDP Component activities, exemplify this response and re-direction of HFDP activities.

Another major change in HFDP resulted directly from the change in DOH administrations and the new priorities noted above. Pressure to re-direct HFDP grew as the pace of implementation moved considerably slower than expected (for reasons discussed in Section 4.1). Frustration with both MSH, focusing on the glacial pace of its contracting actions, and UPecon, concerning a perceived divergence between its agenda and the DOH's interests, peaked in August 1993 when Secretary Flavier informed USAID of his consideration of "proposing a technical package of assistance that will dove-tail with new priorities of my administration". Though USAID was subsequently able to reassure the Secretary that HFDP was important and supportive of his priorities, the need to realign project activities with the DOH's current interests was now inescapable.

USAID and the DOH reached agreement on the new configuration of HFDP by late 1993. Most observers of this change agreed that the re-casting of the project was a beneficial change. Project resources were now focused on fewer and presumably more productive areas. However, this re-focusing also moved the project toward more operational, day-to-day matters. In particular, the HFDP's information generation, analysis and policy formulation model was overtaken by the immediate needs and tasks of the DOH, many of which the Department would have probably undertaken in any case. The overarching goal of stimulating private sector investment to meet national HCF requirements through the creation of a conducive policy environment fell victim to this re-focusing.

The realignment of HFDP gained added impetus from the reduction of USAID's overall program levels which, in turn, required cuts in HFDP's budget. Overall, HFDP was reduced from \$20 million to \$11.7 million. Both the MSH contract and the UPecon grant were also shortened by one year to terminate on September 31, 1995.

MSH's contract was reduced from \$10.878 million to \$5.7 million; UPecon's grant took a somewhat smaller cut, falling from \$5.1 million to \$3.6 million. To accommodate this reduction in the MSH contract, the level of effort from three long-term expatriate advisors was cut from 52 person-months to approximately 25 months. The MSH Health Insurance

Advisor who resigned in early 1994 will not be replaced. Research assistants who have worked with these advisors will take over their duties under the supervision of the remaining senior Technical Coordinator. Planned activities will also have to be reduced or eliminated. In addition to the reduction in technical assistance, perhaps the most damaging cuts will be made in Studies and Demonstrations to accommodate budgetary and time constraints. From the initial planned level of \$2.9 million, the revised studies and demonstrations budget may fall to as low as \$1.6 million. Similarly, the effects of reducing UPecon's grant will translate into fewer activities being undertaken by the team in such areas as training and research. Limited funding remains for short-term assistance, but clearly the overall level of effort of the project has been reduced significantly.

### *Conclusions:*

The political and institutional changes in HFDP have, for the most part, been turned into opportunities for the project to make useful contributions, both in the form of specific products as well as heightening attention about the critical importance of HCF to improving the health status of the country.

Given delays in the start-up of many activities, budget cuts and the shortened duration of the contract and grant mechanisms for technical assistance, potentially serious consequences are foreseeable. In particular, what can be achieved and learned in the time remaining for HFDP will certainly be less than if the project had run its planned course at original budget levels. This places a premium on using remaining HFDP funds as effectively as possible for priority activities. New activities should only be undertaken which can be completed satisfactorily before the end of HFDP and the utility of work completed to date should be maximized through distilling and disseminating key results and recommendations in actionable forms.

Despite the realignment and focusing of HFDP, the project is still left with too many planned activities for the remaining fourteen months. The HFDP operational plan covering the period up to September 1995 includes 113 different activities. Some of these activities have been eliminated since the plan was published in January 1994, and there have been some preliminary discussions to make further cuts. But at present, this leaves scores of activities on the project's docket. What should be of concern is that with a reduced technical staff - in experience as well as numbers - faced with this workload, important on-going activities could be impeded, such as managing and evaluating provincial health insurance, and promoting policy dialogue on Medicare reform.

One other concern which needs attention of HFDP managers is the current neglect of the original goal of stimulating private sector investment. As noted in the first section of this report, the analysis presented in the project paper concerning the HCF needs of the country remains perfectly valid. The government cannot, nor should it, be the sole concern in addressing the country's health care needs. It is only one part, and a smaller part at that, in

finding solutions. The private sector offers a far greater source of financing for future health programs and services than does the government. HFDP needs to direct some portion of its remaining resources specifically to this more macro-level goal.

### *Recommendations:*

1. Give priority in HFDP's remaining work to maximizing the utility of what has and will be produced by HFDP through distilling and disseminating what has been learned in forms intelligible and usable by policy makers and other audiences for this information.
2. Re-examine what HFDP can realistically accomplish, i.e., seen through to a satisfactory completion, and give priority within the five program areas to completing activities with the greatest potential impact.
3. Specification of policies needed to stimulate expanded private sector investments should be a separate benchmark/product of HFDP. This agenda should be acceptable to the DOH which, in turn, should use it to solicit funding from other donors who could finance the development and enactment of these policies, e.g., through a sector assistance program. HFDP should assist the Department to identify and obtain such financing.

### **3.4 Actual and Potential Impact**

*What has been the Project's actual impact and potential impact on financing, access to and delivery of health services?*

#### *Findings:*

Policy projects are often difficult to evaluate for a number of reasons. First, policy development is a process, therefore, the "output" of a policy project is in many ways the process itself. Measuring and evaluating process is not easy since little work has been done in this area, and it poses various conceptual and methodological constraints.

Second, major steps forward in policy development often require that there be a critical mass of basic information, policy analyses, policy reviews, and trained researchers and analysts. In addition, policymakers need exposure to key information and analyses, and the public must have an awareness of the main issues. Building this critical mass was a major objective in the population field in the 1970s and 1980s, and it paid off as nearly every developing country now has a national population policy, a more favorable policy environment, and

many have explicit strategic plans. The approach is not glamorous, it is time consuming, and it is difficult to know when a critical mass has been reached.

Third, evaluation of policy projects are challenging because there are different kinds of policies with differing levels of importance depending on country circumstances. As noted earlier, macro-policies can shape the entire structure of the health sector and have great influence over consumer and provider behavior. These policies include those that affect how health services are financed. Operational policies are manifold and mainly influence the efficiency and effectiveness of health services delivery. To complicate matters further, sometimes macro- and operational policies are at work in the same program area.

Finally, it is important to recognize that this project has only operated for a little more than two years. During that time, its focus was shifted, and the staff and budget were reduced. Therefore, it is unrealistic to expect that major impacts could be achieved under these conditions.

With this context in mind, this part of the evaluation will briefly consider the impacts and potential impacts of the HFDP.

### *3.4.1 Macro Level Policy Impacts and Potential Impacts*

At the outset of the project, it is clear that macro-level impacts prompting structural change in the financing of the health sector were sought. Thus the project steered a course to achieve these types of impacts. The main achievements of the HFDP at the macro level include the following:

#### *a) Raised Awareness and Understanding of Health Policy Issues*

Observers state that during the design of the project in 1991, only a handful of people in the Philippines had a good grasp of the basic health financing issues confronting the country. It is clear that by 1994, there is a much broader understanding of what the health financing problems are, their magnitude, the causes, and what possible solutions are. The project deserves credit for this rise in awareness and understanding, thanks to its efforts to expand the information base, disseminate policy analyses, and foster policy discussions. The evidence to support this conclusion include the scores of research papers, monographs, policy analyses along with a number of seminars, workshops, training sessions, and working groups involving government officials of various levels, scholars, private researchers, health providers, and the media. An increased understanding is revealed in the debates that took place in these events, the issues that are raised in proposed legislation, and the interest of central and LGU officials in addressing health financing problems.

Various persons interviewed expressed the view that the project has helped raise financing issues to national level. Finally, a knowledgeable observer-participant stated that "health

financing was in its infancy at the time that the project began its activities, and that in two years it reached the stage of childhood." According to our qualitative assessment, this statement appears to be an accurate characterization. It is reasonable to expect that this work will form a foundation for further progress in health financing.

One qualification is required in this regard. Much of the awareness raising and improved understanding relates to the public sector. When the project was designed, it was intended to devote a large effort to improve the understanding of private health financing issues and solutions. In the Project Paper, eleven of the thirteen End-of-Project outcomes related to the private sector.

The re-casting of the project dramatically shifted the focus to the public sector. There are still great needs to create and disseminate information on the private sector, involve private consumers and providers in policy discussions, improve policies affecting private providers, increase access to capital, promote public-private collaboration, and rationalize the division of labor between the public and private sectors. Unfortunately, these macro policy issues were not able to be addressed in the HFDP.

*b) Began Process of Creating Local Capacity to Analyze and Influence Health Policy Development*

By virtue of its training activities and its collaborative working relations, the capabilities of staff at the DOH and at the PMCC have been strengthened. Project participants state that the PMCC now has the capability to manage and provide technical assistance to the Quezon P-2 and Bukidnon insurance activities. It is less clear that such strengthening has occurred in the HPDS and DLLO. However, most of these staff members have been exposed to at least short-term training, and the director of HPDS was trained at the graduate level for a year in the U.S. (however, at this time, it is not clear whether she will return to her job or be assigned to another). At the operational level, the IPS clearly gained budget-making capacity through the assistance of the Project.

The development of the National Health Accounts methodology has the potential of creating a strong local capacity for collecting and analyzing health expenditure data if a mechanism can be found to institutionalize it. Similarly, if the Multisectoral Health Policy Forum is

established permanently under private sponsorship as intended by the Project managers, it can possibly play a future role in the health policy debate and formulation.

Perhaps the most lasting impact of the project in this area will be its contribution to reaching the critical mass of expertise required to motivate and inform policy decisions. A look at project lists of papers and reports shows that sixteen Philippine organizations participated in project research and policy analysis activities. In addition, various consultants carried out work, project staff gained experience and expertise in the MSH office, and a number of professors and researchers at the University of the Philippines (U.P.) became engaged in

health policy work. At least 10 graduate students are being trained in health policy related work at U.P. Finally, the development of project demonstration activities have created some expertise at the provincial level. The speech by the Governor of Bukidnon at the launch of the provincial insurance project is certainly evidence of a growing understanding of public health insurance. These involvements will likely have pay-offs for health policy in the Philippines over the next ten years.

Despite progress made in building capacity in the public sector and in the research community, little was done to build capability in the private sector as intended in the original project design. The reasons for this have been discussed.

*c) Began to Influence Resource Allocations to Health Sector*

Various analyses have shown that compared to its Asian neighbors, the Philippines spends far too little on health than it should given its development level. Within the Government health budget, it probably spends too little as well on public health and primary interventions. To address these serious problems, the goal of the HFDP is to "develop the health care market" by increasing government expenditures on health and increasing utilization of health services by lower income groups.

The Project's efforts to help develop the Senate's National Health Insurance bill is a major step in the direction toward improving the health services market and increasing health services utilization by lower income groups. If it can be successfully implemented, and if the HFDP assists in the development of financially viable and equitable Implementing Rules and Regulations for NHI, the project will indeed have made a significant and lasting contribution to the Philippines health sector. Similarly, if the initial studies and recommendations on Medicare reforms can be effectively disseminated, and policymakers motivated to adopt them, the resulting efficiencies in Medicare financing would be a key factor in expanding public insurance coverage. (Curiously, at the time that the project addressed internal efficiency problems in the Medicare system, it was not able to confront larger policy barriers such as the regressive nature of the Medicare tax.)

Supporting the NHI endeavors, and Medicare reforms are the project's insurance demonstration activities - especially the Bukidnon experiment. If this demonstration is successful, it could have some influence on how NHI is implemented in addition to providing health insurance to low-income groups in the provinces who previously had no coverage. In addition, the Quezon P-2 and the Bukidnon activities could also have a positive impact on Medicare efforts to expand coverage to non-enrolled formal and informal sector employees.

The project also addressed resource issues through its assistance to the DOH in developing the National Health Plan (NHP), the 10-Year Investment Plan, and the National Health Facilities Enhancement Plan. If the latter two plans are adopted and implemented, increased tax funds could flow to the public health sector. The NHP could possibly assure that these

funds are channeled to priority health care. Finally, financial viability was addressed by the project in its revenue enhancement activities at hospitals (see below).

### **3.4.2 Operational Policy Impacts and Potential Impacts**

#### *a. Identified Barriers to Greater Efficiency in Medicare System*

The project carried out studies of major problems affecting the Medicare programs such as claims processing, compliance, and organizational structure. In addition, the project is supporting operational improvements, such as testing of computer links between hospitals and Medicare to determine eligibility on the spot. If these findings and recommendations are adopted by the PMCC and member agencies, Medicare could operate more efficiently in the future.

#### *b. Developed Financial, Administrative and Planning Tools for Health Services in Public Sector Under Devolution*

One of the keys to successful devolution is establishing a workable relationship between the DOH and the LGUs regarding the financial, administrative, and technical management of government health services. The project developed a critical tool (the Comprehensive Health Care Agreement) that established this relationship and promises to preserve the basic integrity of the health system. Other HFDP planning tools and operational manuals can help the workings of the retained hospitals, and provide technical and management guidance to devolved hospitals if there is follow-up action on these products. Overall, devolution has proceeded more smoothly than it would have without HFDP involvement.

Through its work with DOH senior managers and hospital directors, the project has strengthened the strategic planning capacity of the DOH and of individual hospital managers. If the tools and techniques developed for this work are extended throughout the hospital sector, curative services will presumably be delivered more effectively and efficiently.

#### *c. Improved Budgeting and Planning Process at DOH*

The DOH budgeting preparation process has become more efficient, accurate, and realistic under the assistance rendered by the HFDP.

#### *d. Enhanced Prospects for Revenue Retention in Public Hospitals*

The project is experimenting with a cost recovery scheme in which hospitals can keep a part of revenues collected. These demonstrations have great significance for the financial viability of both retained and devolved public hospitals if they are successful. If public hospitals universally adopt fee retention schemes, the quality and quantity of public curative

services could increase. The impacts of such programs on private hospitals which make up about half of the hospital sector is unknown however.

### *Conclusions:*

The findings show that in two short years, and despite some severe self-inflicted obstacles, the project was able to make good progress toward improving the health financing policy environment in the Philippines. But as the proliferation of subjunctives above indicates, many of the impacts of the project have to do with *initiating* policy processes rather than *achieving* specific policy and operational reforms. Since most of the outputs in the revised logframe relate to initiating policy processes, it appears that if the project is fully successful in its final year, it will meet the revised end-of-project conditions.

While on paper, it appears that the project will achieve its purpose, it nevertheless, could have carried many parts of its work much further than it did, especially in the area of Medicare reforms and insurance demonstration activities - key elements in Philippine health care financing. The inordinate amounts of time spent preparing technical terms of reference, the internal debates about approaches and sensitivities, the lack of communication, the inability to present proposals to USAID and the DOH that were readily acceptable, and the eviscerating contractual procedures imposed by the MSH home office, all combined to rob the project of the opportunity to move ahead much faster in areas where the work could have had an immediate and concrete impact. Instead, the project now has only a few studies to show for its Medicare reforms efforts, and just one viable insurance demonstration activity is barely underway. A concentrated effort will now be required to bring these activities to their fruition over the next two years.

### *Recommendations:*

The final impacts of the Project are dependent on follow-up actions in the next two years and thereafter. The critical follow-up technical activities are found in Section 3.2 above.

### 3.5 IMPLEMENTING STRUCTURE

*Assess the overall implementing structure developed for the Project, i.e., through Cooperative Agreement, Institutional Contractor, and Personal Services Contractor. Is this structure appropriate? Given the present structure, what modifications are required to enhance project management?*

#### *Findings:*

As discussed in preceding sections, HFDP activities are implemented through an A.I.D. direct contract with MSH and a cooperative grant agreement with UPecon. Both MSH and UPecon provide assistance and services using their own staff as well as contracting with local consulting firms and individuals to carry out project activities. Section 3.2 summarizes the range of activities conducted by the MSH and UPecon teams in the current five program areas.

Initially MSH was responsible for activities with the HCF Mechanisms and Hospital Reform Components. MSH provided the services of the Chief of Party, a Health Economist and a Hospital Management Specialist. Subcontractors to MSH were: a) HIID, which provided technical assistance and training services, b) Anderson Consulting through which the services of the Health Insurance Advisor was obtained and c) CARRA, a newly established local consulting company in the area of health finance which provided administrative and technical services to MSH, including the senior Technical Coordinator on the MSH team. A technical assistance contractor was needed in HFDP because the technical capabilities to carry out the activities envisioned for the project simply did not exist in the DOH or other local institutions. Administrative demands placed on USAID and DOH, including contracting for studies and demonstration services, were also expected to be reduced by using a technical assistance contractor. Given that the initial budget for studies and demonstrations was \$2.9 million and most of these funds would be for contracts less than \$100,000, this was an important consideration.

UPecon conducted basic research and operational studies and provided short-term training and technical assistance. UPecon was initially responsible for the Policy Formulation Component and this included training and assistance to strengthen the newly established HPDS. UPecon also provided training and other services in support of the other two components. Similarly, the results and products of the MSH team were to feed into UPecon's work on policy formulation, particularly in developing an HCF policy agenda. UPecon's responsibilities expanded as Devolution and Public Resource Management emerged as areas of assistance under HFDP. UPecon's budget also included funding for local contracting services for research, studies and technical assistance. \$1 million was initially planned for demonstrations, a large part of which was actually for staff and equipment support to the DOH, but a significant amount remained for external contracting. As with MSH, channelling these funds through UPecon would lessen administrative demands on the

DOH and USAID, especially given the less stringent regulations applicable to contracting under a cooperative grant agreement.

HFDP funds a Personal Services Contractor (PSC) attached to HPDS whose role includes both administrative and technical responsibilities. HPDS was a new organization and the entire area of HCF, for that matter, was new "terrain" to the DOH. Project planners decided that additional in-house assistance would be needed. The role of PSC was viewed as particularly important during the initial year or two of HFDP when the DOH would have to organize to administer and manage HFDP activities. The PSC was also seen as augmenting MSH and UPecon technical capabilities for servicing the project. The PSC's role was also very important in maintaining project momentum prior to and during the start-up the technical assistance teams

The scope of work for the PSC specified that this individual would assist the DOH to utilize project resources, meet USAID administrative reporting requirements, develop internal organizational and administrative systems and procedures pertaining to the project, schedule DOH activities needed for project implementation, coordinate with other projects where complementarity existed with HFDP and coordinate and monitor the work of the long-term advisors on the technical assistance teams. Subsequent work plans through July 1994 have shifted the PSC's functions from its initial emphasis on administrative and organizational responsibilities to greater involvement in the technical work of the project. Physically located in the HPDS office, the PSC functions as a staff person and advisor for essentially all aspects of the project.

Measured on the basis of the output of HFDP, the contractor, grantee and PSC approach has clearly proven successful. The undeniable fact is that despite changes in the political and institutional environment, and despite the considerable frustrations in expediting project activities, HFDP has contributed significantly to understanding HCF issues in the Philippines and providing useful and important assistance and services. Moreover, initial expectations about how these three elements for project implementation would function, in general, have been borne out. The alignment of responsibilities between MSH and UPecon, of course, has changed profoundly with the re-focusing of HFDP into five program areas. Now both teams have varying levels of involvement in each of the five areas. The re-focusing exercise did not, however, change significantly the functions of the PSC vis-a-vis the technical assistance teams, USAID and the DOH.

The evaluation team learned that the function of the PSC in the project has been invaluable. The PSC contributes significantly to project administration. This includes helping the DOH use the technical assistance services of MSH and UPecon, advising on USAID regulations and procedures, serving as an in-house advisor on technical issues, assisting with the planning of organizational and administrative systems and expediting activities by following-up on actions that need to be taken. In each area of responsibility cited above, the PSC has played a constructive and essential role. The assessment that "extra horsepower" would be needed to compensate for the newness of HCF policy work and the corresponding lack of

internal DOH capabilities at the outset of the project appears to the evaluation team to have been on the mark.

On the other hand, the exact role of the PSC - e.g., does he speak for USAID or does USAID speak through him - was at times very confusing. At times, the line between giving guidance versus giving orders has been unclear as a result. The PSC relationship with the technical assistance teams has also been confusing at times. As a contractor, the PSC should be limited to providing guidance, monitoring and/or working with the advisors as a provider of technical assistance on tasks. The evaluation team was informed that the PSC's role has impeded direct access to and communications with DOH senior management and to USAID on occasion. However, there is no evidence that this is a frequent or continuing problem.

### *Conclusions:*

With respect to the continuing appropriateness of the implementation arrangements, no changes are warranted nor, at this late stage in the project, does it make sense to consider alternative implementation arrangements. If measured by project outputs, the present configuration of contract and grantee teams supported by the PSC is clearly working. USAID and the DOH have established clear lines of communication for project management which the recent re-focusing exercise made quite straightforward. In short, there is no indication that changing present implementation arrangements would improve the effectiveness of project management.

The role of the PSC has also been revised during the course of implementation as administrative and management systems have been developed. The shift toward more involvement in technical work will make good use of the PSC function, especially in light of the substantial reduction in the MSH technical assistance team. As the PSC disengages from administrative and organizational tasks, project management needs to assure that these functions are being adequately handled by DOH units.

### *Recommendations:*

- Project management and the technical assistance teams should determine where the PSC's involvement with technical activities could be expanded further, shifting administrative matters to DOH counterparts.

## 4. ASSESSMENT OF MANAGEMENT STRUCTURES AND PROCESSES

### 4.1 Pace of Project Implementation

*What is the extent to which GOP and private sector counterparts are accomplishing the revised project objectives? How do you explain this pace in project implementation vis-a-vis the schedule?*

(The first portion of this question is addressed in Section 3.2)

Several schedules for the implementation of HFDP activities have been produced over the course of HFDP. Initial life of project milestones and benchmarks were developed for the work of UPecon and MSH. UPecon's schedule was submitted to USAID through the DOH in May 1992. Extensive planning using an external consultant was conducted prior to the arrival of the MSI team in July 1992. This work resulted in a detailed agenda and monthly schedule of activities which were projected for the MSH team. These initial plans were intended to accelerate project activities. For example, MSH was led to understand that the plan prepared for them would need adjustments in time, but that it should be followed initially as an operational plan to the fullest extent possible.

These initial plans were then followed by interim operational plans covering the balance of FY 92. With the start of FY 93, work schedules commenced on an annual basis specifying major milestones, key benchmarks which would contribute to reaching those milestones and anywhere from one to several activities which would be carried out under each benchmark. Due dates were specified for each of these tasks. The annual plans would make necessary adjustments to the initial long-range plans based more realistic appraisals of what could be accomplished. In practice, annual schedules needed periodic revisions as project activities adjusted to the DOH's shifting priorities, external events interfered with meeting proposed due dates, unpredicted problems arose, etc. In reality, there were a number of actual work schedules prepared for the project which were amended as events dictated during the course of the year.

Developing initial implementation schedules for the project was guided by the keen interest of both USAID and DOH staff to get activities moving as quickly as possible. Funds were available and needed to be committed to activities as soon as possible. In line with this, the technical assistance teams were instructed to be aggressive in their planning and start as many activities as possible in the first year. At this point in the project, without actual experience with how quickly or slowly certain activities would move, the risk of an aggressive approach to planning was to set unrealistic work schedules and deadlines.

A major source of delay in the implementation of HFDP activities resulted from MSH's excruciating problems with issuing contracts to local firms and individual consultants. Some

\$2.9 million had been programmed for studies and demonstrations under the MSH contract. These funds constituted the major portion of HFDP financing for a broad range of studies, pilot activities and other technical assistance that would extend and expand the capabilities of the MSH team. This work, in turn, would be critical inputs into achieving the results of the project in general, and the work of the MSH team, in particular.

A substantial number of studies and demonstrations were anticipated over the course of HFDP. Using local consultants would further contribute to build that "critical mass" of expertise needed to sustain work on health care finance in the future. When HFDP was being designed, USAID's total program budget exceeded \$400 million annually. To manage this level of funds, projects were to minimize their demands for contract actions by USAID. Recognizing that a significant number of contract actions would be needed for studies and demonstrations, HFDP designers quite reasonably decided that funding for these activities should be placed in the contract for technical assistance. MSH then became responsible for contracting for studies and demonstrations under HFDP. Because a direct USAID contract was used, USAID contracting regulations were applicable to the use of these funds, i.e., MSH had to comply with USAID requirements for contracting.

In principle, this should have been a workable approach. Perhaps initially the number of separate contract actions needed under the "aggressive" operational plan of MSH could have been somewhat daunting. But this should have diminished over time. In practice, MSH failed to meet its responsibilities for managing these funds. They grossly underestimated the skills and experience needed to comply with USAID contracting regulations. It should be made clear that USAID contracting regulations are not unworkable in projects structured like HFDP. These procedures are used repeatedly by USAID around the world. But if you do not understand what is needed, then these same regulations will strangle the best of plans. This is precisely what happened to MSH.

The problem worsened into the middle of 1993 as activities fell farther and farther behind schedule. Frustration and dissatisfaction grew on all sides - in the DOH, in USAID and on the MSH team. The basic problem was that the MSH team in Manila were largely technical experts, a contracting specialist was sorely lacking. MSH staff admitted that they had seriously misjudged the demands of local contracting from the beginning. The USAID Project Officer confirmed that the budget for Studies and Demonstrations was inadvertently missing from the RFP. However, all the way up to the point where the problem became painfully apparent to everyone, MSH continued to misjudge what was needed in this area. When MSH finally hired a Contracts and Administrative Manager in March 1993, they chose someone with stronger financial management skills than contracting experience.

MSH/Boston responded in early 1993 through short-term assistance to develop basic protocols (i.e., models or examples) for different types of contract actions depending on the level of funding involved. MSH hoped that these would facilitate approvals by USAID of its subsequent contracting procedures. However, this proved to be too little too late. Formal complaints about inaction by MSH reached USAID from the DOH in June 1993.

Dissatisfaction continued, resulting in a DOH evaluation of HFDP implementation performance which faulted (heavily by Filipino standards) MSH mishandling of contracting needed for the studies and demonstrations. In response to USAID's earlier expression of dissatisfaction with MSH's performance, MSH acknowledged that the problems resulted from the fact this was the first time they had gone through the process - i.e., start-up delays, they had tried to be "too perfect" at each step and that they had treated each step in the process separately.

The situation began to improve with the visit of MSH/Boston's Contract Officer for HFDP to Manila in June/July 1993. A number of actions were cleared through USAID and contracts were awarded shortly thereafter. The MSH team in Manila was responsible for preparing the Terms of Reference, selecting consultants or obtaining proposals (depending on the type of contract) and estimating budgets. MSH/Boston conducted contract negotiations and retained final approval of contracts over \$25,000 in value. The DOH and others faulted MSH for this arrangement. However, it needs to be recognized that the MSH team lacked contracting expertise and MSH could suffer serious financial losses if audits revealed improper contracting procedures and disallowed associated expenses. This later concern, however, resulted in what all observers, including the evaluation team, viewed as a very cautious and conservative approach to contracting actions by MSH.

Even after MSH/Boston's intervention, problems persisted. USAID found that MSH's submissions continued to be faulting, lacking such mundane things as adequate documentation of salary histories. USAID was forced to reject such submissions from MSH, resulting in further delays until proper documentation was obtained. USAID also reported that the technical proposals submitted had apparently not been re-worked collaboratively by the proposing firm and MSH prior to submission. This resulted in further revisions and delays as USAID was forced to not approve the submission. As late as October 1993, USAID's Office of Regional Procurement was forced to issue additional guidance to MSH to correct these deficiencies.

USAID staff also reported that they believe the procedures MSH has finally developed for contract actions are more complicated and cautious than necessary to USAID requirements. For example, asking two or more times for a "best and final" bid from an individual for a contract under \$10,000 is a good illustration of this point.

The MSH team itself slowed the process further by what many observers, including MSH team members, considered to be excessively complicated, detailed Terms of Reference (TOR). This was exacerbated by internal disagreements among MSH team members over what constituted an acceptable approach and methodology for the activities. In part, this stemmed from too many individuals being involved in the same areas of MSH's work. Component 2 - Health Finance Mechanisms - received the attention of at least three of the technical advisors as well as the Chief of Party. As one observer of the situation aptly described it, too many cooks spoiled the broth. In contrast to these highly refined TOR's, the proposals submitted by local firms and individual consultants in response paled in

comparison. One person involved with the process summarized the problem as "getting too technical, too fast, on too many activities". In a number of cases, it is likely that the cost of staff time devoted to MSH's cautious contracting process, combined with overly detailed, over debated TOR's actually equalled or exceeded the value of contract finally awarded.

At present, the worst of the problems seem to be past. MSH seems to have a much better grasp of how to manage the contracting process. However, the evaluation team was informed by several DOH managers that they are still dissatisfied with MSH contracting. For example, the firm awarded an Indefinite Quantity Contract to a firm which lacks an adequate roster of consultants it can field to provide assistance to LGUs within the Devolution Program Area. The DOH finds itself having to identify qualified individuals for the contracting firm. The lack of an adequate number of qualified individuals and firms with whom to contract has plagued MSH's contracting despite their efforts to develop a consultants roster.

While it is difficult to understand how a firm as experienced as MSH could have such a hard time implementing the local contracting under HFDP, there were a number of external factors contributing to the slow pace of implementation prior to the re-focusing exercise.

The administrative and management structure of HFDP within the DOH, as called for under the Project Paper, had to be developed from scratch. HPDS was a new unit within the DOH (its formation was a condition precedent of the project) while the work of HFDP was also new to the existing DOH units and the PMCC. The PSC assigned to HPDS set about getting DOH and PMCC organized with respect to administrative and management procedures and systems for the project, which he referred to as "setting up the bakery". This resulted in a series of Administrative Orders from the DOH on their management of the MSH and UPecon teams. These directives were detailed to the point of specifying the color of front and back covers of HFDP publications.

"Setting up the bakery" also led to the formation of Working Groups for various aspects of the project. The number of such groups with their attendant meetings proliferated. For example, not only did the project have an overall training committee to oversee HFDP training activities and participant selection, but sub-groups on training were formed within each Component. Monthly, quarterly and annual review meetings were soon augmented with various weekly meetings on assorted project activities. By mid-1993, so many meetings were being held that they were interfering with the pace of work. An informal audit was conducted which verified that the number of meetings had run amok. Steps were immediately taken to reduce this burden.

Despite the organ-o-grams and detailed Administrative Directives on project management, technical advisors who were supposed to work through these channels variously described their experience with the system as "dealing with a tremendous paper flow into a black hole". Too often documents were submitted as directed, but actions did not result. Too frequently papers were lost, misdirected and otherwise went unaccounted for. Working

Groups were reported as suffering from shifting memberships from meeting to meeting, so old ground had to be covered again. Counterparts for an activity became unavailable due to assignment of other work duties. New counterparts would be assigned and the process repeated itself. As it became increasingly apparent that the system was not working, advisors reported that they used informal channels for discussions, reviews and clearance with key DOH managers and then later covered all of the formal steps as specified in directives to create the appearance of conformity. In short, "setting up the bakery" blossomed into a fecund bureaucracy to the detriment of project implementation.

Shifting priorities resulting from a new DOH administration in 1992 adversely affected implementation of HFDP, as it did other projects. A certain amount of uncertainty and confusion about future directions is predictable and normal in this situation. However, the situation did not clarify in time, and directions and priorities seemed to keep changing.

The work on Component 3 provides a good example. The DOH's view on Hospital Reforms went through at least three distinct phases. Initially, hospitals were viewed as an expensive, even wasteful, outlay for the Department. The idea was to take as much away from hospital expenditures as possible. This proved to be politically more difficult than it sounded. So thinking shifted to leaving matters as they stand, but certainly not increasing support or attention to hospital-related issues. However, devolution resulted in giving responsibility for health services and the associated personnel and facilities to the LGUs. The DOH quickly found itself in control of only the 45 retained Regional Hospitals and Medical Centers. DOH interest in hospital reforms and administration grew, in part, facilitated by requests from LGUs for guidance on managing the devolved hospitals. The ramifications of such shifting priorities carried over into the work of HFDP, in effect, moving "the goalposts" for consultants working in this area.

A similar change in project priorities also occurred during this period. At first, the teams got busy on studies they were assigned to conduct or manage. But word soon circulated that studies were unpopular with the Secretary; demonstrations were now the priority. Despite the sequential plans that had been developed and approved where studies and research first identified testable options which would lead to field testing, demonstrations were moved forward in the agenda. Approximately two months of time was devoted to identifying, short-listing and selecting demonstrations. The next shift centered around devolution. Factoring devolution into the core of HFDP activities became a guiding priority.

Within the Components, the evaluation team learned that priorities among activities would rise and fall. It was, as one person described it, "like standing on shifting sands". Despite the initial admonition to be aggressive in their planning, the technical advisors came to realize that shifting directions and priorities was one way of resolving the over-programming of work plans. As directions shifted, the priority of specific activities followed suit. What was of burning urgency a couple of months earlier was subsequently overlooked and moved to the back-burner. While such changes may be understandable in light of the situation the

DOH confronted, it did not facilitate meeting all those carefully planned and specified benchmarks guiding HFDP implementation.

One final point about the pace of implementation returns to the initial long-range plans and the FY 92-93 Operational Plans illustrated by MSH's situation. On the one hand, the five year, long-range plan given MSH, looks impractical simply on the basis of the amount of time allocated to specific steps within an activity. MSH's experience with this plan quickly bore this out. Not only was the plan unrealistic in its timing, but the individuals in office when the plan was prepared were gone or leaving by the time MSH started work. In other words, the agenda given MSH responded to a different DOH. On the other hand, it was made clear to MSH that this plan was to be treated as starting point for work - it was not a general guide. Complying with the admonishment to be aggressive resulted in an Operational Plan for FY 93 which USAID itself noted was very optimistic, but MSH was encouraged to proceed upon the advice of the PSC.

### *Conclusions:*

The worse consequence of MSH's failure to manage adequately its contracting responsibilities is that it set back the start of HFDP demonstrations which, arguably, provide the most convincing evidence for guiding policy changes or developing health care systems. Time lost in starting demonstrations, combined with the shortened period for technical assistance, means there is insufficient time to complete certain demonstrations within the time frame of the project. This will very likely reduce the overall impact of the project and this is directly attributable to MSH's failure to perform a critical function of their contract adequately.

The claim offered by MSH that the level of effort required for contracting was not clear in the RFP is simply not credible. By the time project negotiations were completed, the demands of contracting were undeniably obvious. When MSH finally hired an individual to support this function, they failed to hire someone with extensive experience with USAID contracting. Moreover, in light of the continuing problems with contracting, though nowhere as severe as in the past, MSH's response of short-term assistance from Boston was clearly insufficient. More concerted efforts, such as a change in their long-term staffing, would most likely have been a more effective response by MSH to its problems.

In fairness to MSH, when the contracting morass came to a head in June 1993, MSH was roundly criticized for having created false expectations for what would be accomplished. There is no denying false expectations were created, but that resulted as much from the USAID's directions to be "aggressive" in work planning. Such aggressive planning runs a high risk of setting the planners up for failure. Moreover, false expectations were being created from the outset with the preparation of an agenda for MSH which offered unrealistic time frames and workloads. In other words, USAID and the DOH cannot have it both ways.

Fortunately for the project, the re-focusing exercise and the changes it produced in project management within the DOH should eliminate all or most of the problems cited above. The management style and broad priorities of the DOH are clarifying, so it is likely the problems due to shifting directions of the Department are at least declining from the 1992-93 period. However, project managers need to remain vigilant that the "bakery" so deftly created with the assistance of the PSC does not again start churning out too many "bureaucratic cookies" - e.g., proliferating working groups, an overabundance of meetings and administrative directives which look good on paper but do not work.

#### *Recommendations:*

1. USAID and DOH project management should insist that MSH make every effort possible to fill the position of Administrative Officer (which will be open with the departure of the Chief of Party in July 1994) with someone with extensive experience with contracting, and preferably with USAID contracting experience, such as a former USAID FSN Contracts Officer.
2. Keep the management systems of the project as streamlined as possible - "lean and mean" should be the guiding principle.

## 4.2 Constraints and Opportunities

*What are the major constraints, weaknesses and vulnerabilities in project implementation and how can these be remedied? What are the strengths and opportunities and how can these be maximized?*

Preceding sections have discussed various constraints, weaknesses and vulnerabilities HFDP confronts as it enters its last two years of implementation. These include such issues:

- a) the inability to undertake the number of studies and demonstrations due to reduced technical assistance and delays in contracting for these activities and how the project's remaining resources need to be concentrated on completing priority activities;
- b) the need to maximize the utility of information generated by HFDP by distilling and disseminating these results in forms readily understandable and usable by decision-makers;
- c) technical weaknesses in certain on-going work, such as the continuing lack of a baseline in the Bukidnon demonstration despite months of implementation;
- d) impediments due to administrative and organizational arrangements which should be eliminated or minimized by the re-focusing of HFDP;

- e) the effects of shifting directions and priorities within the DOH on the accomplishment of HFDP's work and the prospect that the Department's general direction is clarifying and stabilizing; and
- f) the loss of attention to more macro-level HCF issues as re-focusing has led to a concentration on more immediate operational matters, in particular, at the expense of developing a policy environment conducive to private sector investment in health care management and services, and need to give attention to this during the remainder of HFDP.

Noted earlier in the report is the evaluation team's concern about the institutionalization of capabilities in the DOH and PMCC necessary to sustain the progress made by the project thus far. This will be discussed in more detail below.

Similarly, the preceding sections have discussed various strengths of HFDP and opportunities available to the project. These include:

- a) the number of products of the project which have significantly increased the body of information about health finance issues in the Philippines and the potential future utility such information has in guiding decision making and policy formulation;
- b) the significant assistance HFDP has provided to the DOH and PMCC in the preparation of NHI legislation and the opportunity to facilitate implementation if the legislation is enacted through the preparation of Implementing Rules and Regulations;
- c) the various studies completed to date on the Medicare system and the potential to make important improvements in the system;
- d) the results of work on improving the management and operational efficiency of devolved, retained and private hospitals and the timeliness of such guidance as the DOH responses to the changes of devolution;
- e) the contribution UPecon has made to assisting the DOH identify strategies and mechanisms needed for a devolved health sector;
- f) the development of strategic financial planning and articulation of health sector goals and budgetary resources needed to achieve those objectives; and
- g) the initiation of work on Standards, Licensing and Regulation which is of critical importance to the DOH meeting its new responsibilities in a devolved health sector.

Previous sections have noted the progress made in facilitating the development of a pool of local expertise needed to continue work on health financing issues. The evaluation team sees this as an opportunity of the project to further the institutionalization and capacity building objectives of HFDP, discussed below.

#### 4.2.1 Technology Transfer, Institutionalization and Sustainability Concerns

##### *Findings:*

A major objective of HFDP is to strengthen the DOH institutional capacities for health policy development necessary to improve the health care market in the Philippines. This section concerns the extent to which these capacities have been established through technology transfer and institutionalization.

##### *a. Institutional sponsorship for policy development and health care financing concerns.*

The Project has benefitted from the strong policy orientation of the DOH Project Director, concurrently the Undersecretary and Chief of Staff. Despite the DOH Secretary's preference for action-focused programs, the Project Director has provided consistent sponsorship for the different HFDP activities, and has given these activities his personal attention and presence within the constraints of his overloaded work program. As Chief of Staff in charge of the Department's reorganization, he has supported the Health Policy Development Service (HPDS) as a major organizational unit in contrast to cuts, mergers or reduced status in other major DOH Services. He has repeatedly made public statements that more resources will be allocated to policy-related work in the DOH.

Another important development that has enhanced the appreciation of DOH leadership for health finance policy development is the ongoing devolution of health care delivery to local government units. The Department has had many problems in implementing the devolution process which has magnified the need for sound policy advice on such matters as the Magna Carta for Health Workers and various issues related to managing a devolved health system. The Project has accommodated these controversial issues in its research activities; likewise, the demonstration projects on community health financing sponsored under HFDP are clearly aligned with the DOH strategic goal of "Health in the Hands of the People", and enjoy strong support from both the DOH and PMCC.

Nonetheless, the present DOH leadership places priority on concrete results. This accounts for the lack of enthusiasm and support for studies that have longer-term payoffs without immediate practical application. Consequently, the DOH has pressed HFDP to make its studies more responsive to the Department's current policy priorities, and that studies focus

on showing how certain policy directions (e.g. national health insurance) can be made to work rather than on why they may be difficult to adopt.

Despite a strong personal and professional commitment to the policy-related tasks of the DOH, the Project Director has not been able to provide sustained technical direction and support to the Project because of his overstretched work schedule. The same is true of the Project Manager, concurrently the Undersecretary for Health Facilities, Standards and Regulations, who oversees the entire HFDP in addition to his other regular assignments. All these constraints notwithstanding, it is encouraging to note that the Project Manager has increasingly taken many initiatives to accelerate the completion of project outputs. For example, the creation of only one Technical Working Group for each HFDP program area is one such initiative. The formation of a "hospitals superbody" is another idea being studied to oversee the implementation of hospital management reforms which he expects the DOH will adopt as a result of HFDP.

*b. Provision of financial and human resources to sustain project gains.*

The 1994 and 1995 DOH budgets reflect increasing support to the areas covered by HFDP. Similarly, PMCC's budget has provisions for more Program 2 demonstration projects. The Undersecretary and Chief of Staff has very specific targets for the ratio of DOH budget that will go to the HFDP-related areas. While there are no guarantees that the 1995 approved appropriations for the DOH will reflect this support for policy development, SLR and national health insurance, there is evidence that the DOH and PMCC leadership are prepared to commit increased levels of budget support to sustain HFDP initiatives beyond the project life.

The picture with respect to staff resources is less definite, and therefore, less encouraging. To date, the DOH reorganization has not been finalized; the prospect of an early resolution of reorganization issues, including approvals from the Department of Budget and Management, is unlikely. Thus, while the HPDS continues to have legitimacy in the current DOH structure, the proper staffing of the service is not assured.

A combination of factors contributes to the staffing uncertainties in HPDS. The Attrition Law only allows recruitment from within DOH. There is an increasing shortage of good technical people due to natural attrition and retirement, thus strong competition for the good staff. The number of new programs being started in the DOH is stretching available staff beyond their actual or preferred involvements. The amount of work related to the Department's program delivery thrusts is claiming the time and energy of even the current HPDS staff, and this trend is not likely to change in the short run. DOH staff working in other program areas, e.g., SLR, NHI, Devolution, are in a similar situation. Finally, the proliferation of Officer-in-Charge designations, even in the flagship programs of the Department, has created a pervasive climate of anxiety and uncertainty in the DOH and is discouraging people from going into new and untested areas such as HPDS.

c. *Institutional consciousness and legitimacy of health policy development and health care financing.*

The evaluation found that a major accomplishment of HFDP is that it has raised the consciousness of and appreciation for the importance of health financing as a DOH concern, particularly in the light of devolution. This consciousness-raising is evident both within DOH itself and with DOH institutional partners. Stakeholder groups (health care providers, NGOs, local governments, academics) outside of DOH, especially those who have been involved in the various HFDP consultations and studies, have likewise been educated on the importance and urgency of health financing issues. Once the project outputs are effectively disseminated (i.e., marketed), this initial consciousness can be mobilized to generate a more broad-based support to health financing reforms. As one DOH official put it, "Now we feel more confident about discussing health care financing, and it is no longer just the monopoly of those health economists!"

However, health financing issues continue to compete for the attention and priorities of DOH officials and technical staff because of the many other programs for which they are responsible. In fact, since health financing concerns fall neither among the campaign-focused social mobilization activities of DOH (such as Health for More in '94), nor in the category of regular service delivery programs (such as Family Planning, TB Control, etc.), it is certainly not yet a top-of-mind concern in DOH.

d. *Building the capacities of HPDS and Medicare.*

HFDP targeted institutional capacity building efforts on HPDS and PMCC. Both have benefitted from: a) working closely with the MSH advisers on specific studies and/or demonstration projects; b) doing actual policy development work in the context of both MSH and UPecon activities, workshops, etc.; and c) gaining exposure and training through foreign scholarships and study tours. These work-cum-learning experiences have generated both knowledge and confidence that they needed to become better advocates of the project's goal and strategies. It is important to recognize that when the project started, HPDS was still a brand-new unit with minimal capacities, and the PMCC staff had been largely focused on operational issues. Significant progress has been made in preparing both groups to steer and participate in health policy development work.

Since there are relatively few experts in the health care financing area in the Philippines, HPDS recognizes that it will have to rely on tapping a network of individuals and institutions to do work for the Department. A large part of their work will involve developing scopes of work, contracting, and managing the consultants and researchers. Unfortunately, they have not been able to develop these research management capacities from either the MSH or UPecon. The transfer of technology has been hampered by both the working arrangements (see Section 4.3), the lack of DOH staff who work exclusively on project activities, and the start-up delays and subsequent catch-up strategies of the UPecon and MSH.

An earlier evaluation report on HFDP indicated certain problems in the management of the training program of the project, particularly with regard to selection of trainees, utilization and placement of masters degree trainees, support to training outputs submitted, and follow-up of training results. Project documents indicate that a HFDP Training Committee has been directed to attend to these issues, and that both MSH and UPECON would support any remedial efforts. The evaluation team was unable to determine the extent to which new capacities gained through project-sponsored training are being utilized in relevant ways in the DOH and its partner institutions.

The HPDS expressed frustration in being unable to put the policy development process in place within the DOH. This is a result of the multiple roles they are currently playing. They serve as the overall HFDP secretariat; they are themselves being trained both on-the-job (in some of the HFDP studies) and in formal courses; and they are supposed to design and install the DOH policy development process (with the help of UPECON). Given the limited number of well trained HPDS staff, limited practical experience and minimal organizational clout, it is difficult for HPDS to institutionalize the policy development function in the Department.

*f. Building institutional networks for sustainability.*

A number of local educational, training and research institutions have been able to improve the research base for health policy development, strengthen their own internal teaching and research capabilities, and help build DOH staff capacities through degree and non-degree programs. Because the DOH leadership has increased their support for work on health financing issues, there is now greater interest in these issues as areas for study and experimentation.

The Multi-sectoral Health Policy Forum, supported by UPECON, provides an institutional mechanism for policy consultation, validation and advocacy. Through this Forum, health financing issues can be kept on the national agenda, and policy proposals can be enriched through the inputs of stakeholder groups who are represented in the Forum's membership.

The involvement of private health care providers in the crafting of Medicare and hospital management reforms is another good mechanism for project sustainability. HFDP has allowed HMOs, medical associations and hospital owners/managers to work in joint studies with the DOH and PMCC on sensitive issues of common concern. In other instances, they have been contracted to carry out studies. This collaboration, albeit tenuous and sometimes difficult, is nevertheless slowly building up an informal network of health policy reform advocates.

The project supports the growth of local training and consulting capacity in health policy development, particularly in health financing. The DOH is increasingly concerned about building a stronger technical support base at the regional and provincial levels, in light of the growing requirements of devolution. The project's performance in this area to date is mixed.

UPEcon's work program includes the provision of institutional support grants to research and training institutions in selected regions of the country, precisely to build a local support base for the DOH. While current HFDP plans include institutional support grants to nine institutions, only four of them are regionally based. The DOH has indicated some apprehension about the selection of these institutions and the sub-grant agreements with respect to the Department's needs and the development of human resource capacities in health policy.

Though MSH contracting problems and the overall reduction in project funding will reduce the use of local consultants in project activities, what has been done in this area has created greater receptivity by the DOH to external assistance for policy-related work. In time, this should help to build a pool of local consultants in health policy development, because the DOH's policy research needs will continue to expand as it becomes a more policy-oriented institution. (The issue of building a pool of local expertise is discussed in greater detail below).

### *Conclusions:*

The mixed progress of institutional capacity building in HFDP mirrors the mixed support the project has in the DOH. The project has benefitted from the interests and support of the Undersecretary and Chief of Staff (Undersecretary Tan) and the Project Manager (Undersecretary Nanangas). On the other hand, the priority the DOH places on action-oriented campaigns and on immediate operational needs has not helped HFDP establish credibility in the Department (though the re-focusing exercise should strengthen this linkage).

Putting increased staff capacities to good use is both a self-evident need and the action which DOH can best control. Deploying the HFDP-trained personnel in health policy/health financing-related assignments must be pushed by the Project Director himself, given the organizational realities in the DOH. Using the training outputs, or building on them, must be part of HPDS' accountability for institutionalizing the DOH policy development process. In this connection, the completion of the Health Research Agenda (a 1994 UPEcon benchmark) must be accelerated so that it will help to focus future trainees on priority health policy concerns, thus ensuring the usefulness of their training.

Significant progress has been made in heightening awareness about health finance policy development in the DOH. This has contributed to establishing a legitimacy for HPDS as a key organizational unit. However, unless the status of HPDS in the DOH is formalized (i.e., it becomes part of the plantilla), these gains will be lost. For example, policy-related information and proposals will have difficulty finding their way into concrete decisions, actions and issuances within and outside the Department. Similarly, the initial policy development work supported by HFDP in other DOH units (HOMS, LGAMS, etc.) needs to be solidified through allotment of needed staff and time needed to complete work up to the

point of policy adoption. Otherwise, policy development will not be taken seriously and will not build the needed track record of success.

The Project Director and the Project Manager need to give top priority to completing the staffing for HPDS, ensuring that the HPDS leadership is credible both inside and outside the DOH, and protect the time commitments of DOH staff who are now involved in framing and marketing the various policy proposals coming out of the HFDP. It must be emphasized that in this area, half-measures will no longer work.

Regarding regional support grants to build local capabilities, UPecon needs to establish such agreements with more regional institutions. There are fifteen regions where health services have been devolved to local governments. If possible, additional project funds need to be earmarked specifically to build the capabilities of DOH partner institutions at the local level in a more focused and accelerated way.

### *Recommendations:*

1. The Undersecretary and Chief of Staff needs to assure that individuals with health finance policy training are assigned to positions which maximize the use of these skills.
2. Until the DOH re-organization is finalized, the DOH Project Director and Project Manager need to identify interim measures to bolster the legitimacy of HPDS' role in health finance policy formulation within the Department. This includes ensuring adequate staffing, work time and leadership for the unit.
3. DOH management needs to assure that the Services involved with health finance policy development, e.g., LGAMS, HOMS, have adequate staff, work time and budget to complete activities initiated under HFDP.
4. The number of Regional Support Grants needs to be increased. UPecon should be instructed to re-examine its plans and budget in this area to assure this occurs before the termination of its present grant agreement in September 1995.

## 4.2.2 Strengthening the Gains Made Toward Building Local HCF Expertise

### *Findings:*

One of the constraints to HFDP's implementation has been the relative lack of local expertise in the area of health care finance. In large part, this is due to the lack of attention to HCF issues in the Philippines prior to HFDP as opposed to the lack of individuals with the requisite skills and pertinent experience to work in this area. Admittedly, HFDP has had difficulties at times identifying and contracting with such individuals, but the number of products completed and underway demonstrates that local expertise can be attracted to the HCF area.

Though not a major stated objective or output of HFDP, the project did purposefully set out to help develop a pool of local HCF expertise. This is the obvious purpose for the training activities of HFDP, particularly the long-term domestic and U.S. training. Building local expertise is an important element of the grant to UPecon, i.e., to encourage researchers and other individuals with the appropriate skills to work on project activities and thereby gain experience with in the HCF area. Similarly, the studies and demonstrations budget under the MSH contract is, in effect, a local currency fund which creates an opportunity for local consultants and firms to gain experience in working on HCF issues. Again, as the number of sound technical reports and studies demonstrates, HFDP has made considerable progress toward developing this body of local HCF expertise. Various economists and other analysts with pertinent skills now have greater experience in the HCF area than prior to HFDP. Within the MSH contract, the participation of CARRA as a sub-contractor helps to develop a local consulting company concentrating in HCF-related work.

The reduction in HFDP's budget and the MSH contracting morass has undercut efforts to develop local expertise. As noted earlier, the contracting problems MSH encountered will result in fewer studies and demonstrations being conducted, in turn, meaning fewer opportunities for local contractors to work in this area. The overall reduction in project funding obviously results in less resources being spent on activities which would have engaged local consultants. The studies and demonstrations budget alone will be reduced almost in half.

This raises concern over how sustainable these gains are after the completion of the project and what can be done with remaining project resources to increase the likelihood of this expertise and work on HCF continuing after project completion. Admittedly, there is not much the project can do other than direct as much of its remaining resources as possible into activities which continue to create opportunities for local contractors and firms in the HCF area.

The recommendations of the evaluation concerning the priority that needs to be given to maximizing the utility of HFDP outputs are totally consistent with this. Limited funds which have been held in reserve outside of the UPecon grant and MSH contract are available. Additional funding may be identified as project priorities and the feasibility of completing activities within the time frame and manpower limits are reviewed. What is needed is a mechanism for using these funds.

As the DOH's Performance Evaluation of December 1993, emphasized, the costs of working through a standard USAID contract are considerably greater than the costs associated with the same work carried out through a cooperative grant agreement. This was hardly a "finding"; contracts are simply more expensive than cooperative agreements with respect to overhead costs. In other words, it costs more to spend money for project activities through a contract than a grant. This has nothing to do, per se, with MSH and UPecon; rather, it reflects differences in the implementation mechanisms. The greater overhead expenses of contracts is warranted on the basis of obtaining types and/or levels of expertise, capabilities, etc. not available through other sources. The MSH contract did serve that function prior to the budget reduction, i.e., it was a sound decision to contract with a U.S. firm for specialized technical assistance for the project. A grant to UPecon, on the other hand, gives access to local expertise, helps to build that expertise and the organization, and does so at a lower cost than a direct contract. The UPecon grant served all of those purposes.

With the re-direction of the project toward more operational program areas, short-term local contractors are sufficient for most of the activities HFDP will undertake over the next two years. With the reduction in level-of-effort and time-frame for provision of technical assistance due to budget cuts, there is less justification for the long-term, specialized expertise the MSH offered. Moreover, limited project resources need to be maximized at this point and the higher costs of a direct contract cannot be justified. The UPecon grant, in contrast, offers a more cost-effective mechanism for accessing local contractors which also serves the objective to sustaining local HCF expertise. As to directing UPecon works to meet HFDP's objectives, there is essentially no difference in principal in USAID and the DOH exerting control over the use of grant versus the use of contract funds.

UPecon has not encountered the contracting problems that MSH so painfully experienced at considerable cost to the project. In large part, this is due to less rigorous standards which apply to contracting under a cooperative grant agreement. Annual audits of the grant required by USAID have not found any significant problems in UPecon's contracting procedures and administration. In short, they are capable of handling local contracting for HFDP activities. However, the evaluation team was informed by various respondents that a major weakness in the working relationship between the DOH and UPecon is the latter's perceived inflexibility to be more responsive to the interests of the DOH. The contrast between the assessment of the MSH versus UPecon teams by interviewees is very telling. The MSH team was consistently described as proving high quality expertise much appreciated by the DOH and PMCC and whose advisors functioned as consultants responsive to the interests of their clients. In stark contrast, UPecon was viewed as less attuned to the

Department's directions and needs, functioning instead as independent academic analysts who would advise the DOH on what their views and perspectives were. In all fairness to UPecon, its grant agreement specifically called for generic research and a strengthening of academic training in health finance. UPecon can hardly be faulted for meeting the terms of its grant agreement.

Admittedly, this distinction is somewhat overdrawn by interviews and examples of UPecon work attuned to DOH and PMCC concerns can be cited. Arguably, there is value in having an independent body of analysts detached from the political concerns of the DOH. However, the DOH is the principal counterpart in HFDP and the DOH clearly prefers that HFDP resources be used at this point in time for services of consultants working in the five program areas attuned to DOH interests. They are not interested in funding an independent "think tank" whose products have less direct, immediate or operational application. A case in point cited by respondents is UPecon's advice to the DOH not to support NHI legislation when a firm and binding commitment to do so had already been made. The political embarrassment and lost opportunity to influence legislation that might be passed with or without DOH participation ignored in such advice was nothing short of inflammatory to DOH senior officials. Moreover, in light of the shift away from more macro or sectoral policy work to a more operational orientation produced by the re-focusing exercise, academic generic research seems out of step with the project's current direction.

### *Conclusions:*

Though progress has been made in developing a body of local expertise in the HCF area, this development is clearly in a nascent stage. Continued engagement of these individuals and firms in HCF activities is probably the best HFDP can do to assure the continuation of this expertise. In light of the re-focusing and budgetary reductions of HFDP, the most cost-effective mechanism for using remaining project resources for this purpose, as well as following other evaluation recommendations, is the UPecon cooperative grant agreement. In principle, there is no limit on the amount an existing grant agreement can be increased other than the capability of the grantee to adequately administer the funds, which is not an issue in this case. However, any continuation of the UPecon grant must be preceded by a clear re-orientation of work consistent with the current operational project focus. In short, the independent "think tank" role is undeniably useful, but out of step with the project given the changes in budget and focus that have made.

### *Recommendation:*

1. Discuss with UPecon representatives the proposal to extend the grant agreement and the changes in orientation toward the DOH that need to be made. If there is agreement, proceed with the following two recommendations.

2. After reviewing HFDP planned activities as recommended earlier in this evaluation, use "de-committed" funds from this exercise, plus reserve funds to amend the UPecon grant agreement through September 1996.
3. Amend the original UPecon grant agreement to bring it into line with HFDP's five operational program areas and to orient UPecon's work to the role of DOH consultant as opposed to independent advisor.
4. Review UPecon's benchmarks for the remainder of the existing grant agreement to assure consistency between upcoming work and DOH directions and interests. Use the benchmark exercise to establish this consistency for the amended agreement covering the period of October 1995 through September 1996. USAID and the DOH should review all terms of reference for UPecon-funded work prior to activity start-up to assure this consistency is maintained.

(See section 4.3 for a related recommendation about changing UPecon's future project management of HFDP activities.)

### 4.3 Administrative Structures for Project Management

*Assess the administrative structures established by the Grantee (UPecon), the Institutional Contractor (MSH) and the DOH/PMCC to manage their respective project activities. Are these adequate and responsive? How can project management be improved at the Grantee and Institutional contractor level?*

#### *Findings:*

The three component and then five program area configuration served as the basis for DOH/PMCC, MSH and UPecon administrative structures for managing project activities. The administrative arrangement of the DOH/PMCC appeared straightforward. The Senior Undersecretary -Chief of Staff served as Project Director. First the Service Chief for Management and Advisory Services, within which HPDS was established, served as Project Manager and Component 1 (Health Policy) manager. The executive director of PMCC headed component 2 - Health Insurance and the Undersecretary for Hospitals was manager for Component 3 - Hospital Reform. The MSH and UPecon implemented their activities within each of these components under the supervision of the respective Component Managers. As Section 4.1 discussed, this apparently simple organizational structure led to a proliferation of Working Groups and frequent meetings which did not prove to be a particularly effective administrative system.

With the re-focusing of the project into five program areas, the administrative structure was changed accordingly. The Chief of Staff continued to be the Project Director and the former

Component 3 manager became the Project Manager, elevating this role to the Undersecretary level. The appointment of an exceptionally effective Deputy Project Manager has greatly improved the DOH's management of HFDP activities. The Project Manager also serves as the manager of the Health Insurance program area. The DOH Service Chiefs of the units directly related to the four other program areas serve as Program Managers (i.e., the Chief of LGAMS is the Program Manager for Devolution, the Chief of HPDS for Policy Process, the Chief of BLR for SLR and the Chief of IPS for Public Resource Management).

The Project Director and Project Manager approve annual operational and budgetary plans of MSH and UPecon. Subsequent review and approval of TORs and activity budgets are performed at the Program Manager level. The number of working groups and meetings has intentionally been minimized. With the integration of MSH and UPecon activities within each program area, the number of different DOH counterparts for the advisors has increased (i.e., instead of one principal counterpart/manager, an advisor might now deal with three or four Program Managers). However, with a more streamlined clearance process, this should not complicate the review and approval process, periodic reporting on progress, etc.

The milestone/benchmark/activity format has become the project standard for operational planning, periodic progress reviews and annual performance reviews. MSH and UPecon operational plans are also integrated into one operational plan for the project and periodic review meetings are held jointly as opposed to separate meetings with each group as was done previously. Combined with standard financial reporting and quarterly progress reports, the current administrative system is reported as an effective means for planning and monitoring project performance. In short, the evaluation team sees no reason for DOH to make further changes to these administrative arrangements at this time.

An issue raised by HPDS staff concerning implementation arrangements is the physical location of the technical assistance teams at the UP campus and in Makati. It was reported that this arrangement impedes regular interaction with the advisors, precludes DOH staff (particularly HPDS) participation in project activities and interferes with the general process of technology transfer from the advisors to the DOH. The location issue has been raised a number of times over the past year with no resolution to date. Early in 1994, a plan was developed which specified areas where DOH staff could participate in project activities, the number of staff which could be involved and the duration of this participation. For undetermined reasons, no action was taken.

MSH staff reported that they had expected to be located in the DOH from the outset of the project and had not resisted such a move even after locating in Makati. The basic problem has been the lack of adequate space for MSH and UPecon advisors in the DOH. For undetermined reasons, the DOH has simply been unable to provide sufficient space to make this relocation possible. Even accepting the view that such proximity is necessary for staff development, technology transfer, etc., the potential for this to occur is now greatly diminished in light of the departure of four MSH long-term advisors from the project.

MSH's administrative structure consisted of a Project Director based in Boston; a Chief of Party/Project Administrator; a Technical Coordinator responsible for all technical work under the Contract; a Health Economist, Hospital Management Specialist and Insurance Specialist assisted by four Research Associates, a Contracts Administration Manager, Finance Manager, Office Manager and support staff. During the course of HFDP, MSH made personnel changes to improve their office operations. MSH administrative operations are reported as running smoothly now. However, by mid-August, the only long-term, senior technical advisor left on the contract will be the Technical Coordinator. An Administrative Officer will be hired to perform the former Chief of Party's administration duties. Research Associates are expected to assume the duties of former long-term advisors under the supervision and direction of the Technical Coordinator.

UPEcon's administrative structure consists of a Project Coordinator working on a part time basis; a Project Director; a recently appointed Deputy Project Director; and Project Officers for Training, NHADB, the Region VII Demonstration Project and Office Administration. The previous lack of a Deputy Project Director has been especially troublesome. DOH and USAID project managers have repeatedly requested that a Deputy Project Director be appointed. This was finalized only during the period of this evaluation.

The evaluation team learned of considerable DOH dissatisfaction with UPEcon's administrative system. Section 4.2 discussed the DOH's perception that UPEcon has not been sufficiently attuned to DOH interests and priorities. UPEcon operations are largely dependent on the Project Director who, unfortunately, is often unavailable when needed. The widely recognized expertise of the Project Director has resulted in too many conflicting demands on his time, which has occurred at the expense of the project. The evaluation team was informed that UPEcon's responsiveness has also degenerated to the point of becoming unsatisfactory in a number of instances. Meeting benchmark/product deadlines and requests for assistance with various tasks were cited as current problems.

There is also the perception that the Project Director's domination of UPEcon's role in the project and its work with the DOH and PMCC has inadvertently impeded the participation and professional development of other UPEcon staff in the project. Even if this occurs only periodically, this would conflict directly with the project's objective of developing UPEcon as a center of HCF expertise and capabilities. In short, these problems indicate that the UPEcon Project Director is apparently spread too thin across too many activities to the detriment of the project.

Perhaps most disturbing to various individuals working on HFDP is a very sensitive problem concerning a perceived conflict of interest in the role of the UPEcon Project Director in light of his former position as Chief of Staff in the Bengzon Administration. The MSH/CARRA Technical Coordinator, who was also a former Undersecretary in the Bengzon Administration, was reported as causing difficulties at the outset of the project, but has become less problematic to the DOH over time for various reasons.

As a result of the UPecon Project Director's association with the former Administration, the evaluation team was informed that the credibility and advice offered by the Project Director is, at times, in question. On several occasions, this problem has flared to crisis proportions in the DOH, requiring USAID's O/PHN's Chief to intercede on the behalf of the Project Director. This has been a recurring disruptive irritant within the overall project team.

Senior USAID and DOH officials have met on several occasions to resolve these concerns. Lack of trust or questions about underlying motivations are denied in these meetings, but the problem then re-occurs. The situation is confused by the fact the Secretary himself just recently requested the UPecon Project Director to work on a particular task for him, suggesting no lack of confidence on the part of the Secretary. Yet, the evaluation team was informed by other DOH officials the problem is real and not diminishing. An extremely telling fact is that only one person interviewed by the evaluation team stated the technical and substantive inputs of the UPecon Project Director offset the costs that his role has imposed on the project.

### *Conclusions:*

The DOH's present administrative arrangements for the project appear to be a genuine improvement over the past. The new structure is still relatively new, but the evaluation team heard of no serious implementation problems which can be attributed to these arrangements. With the current set of DOH managers assigned to HFDP, it appears on all counts that the DOH has a well organized project team in place.

The issue of where the technical advisors are located has, in large part, become a moot point. Moreover, the importance of the location of the advisors may be overdrawn. In refreshing contrast to other projects, good working relationships between advisors and counterparts have been characteristic of HFDP. To move the remaining technical advisors now to the DOH with only fourteen months of work remaining is likely to cause unnecessary disruption to project work.

Alternatively, if DOH managers feel strongly about having greater interaction with the Technical Advisors, then they should consider seconding staff appropriate for an activity to work a day or two (or more) each week at the technical advisors' offices. Given the shifting and multiple work assignments of DOH staff, working in the advisors' offices would assure seconded staff the opportunity to concentrate on the task at hand without being pulled off to other duties. That arrangement is likely to facilitate technology transfer and skill acquisition far more than moving the advisors from their current offices to the DOH.

Even with short-term assistance from some of the departing MSH advisors, the possibility exists that the remaining staff will be overwhelmed by a combination of workload and administrative demands even with the hiring of a new Administrative Manager. Contracting actions are still pending under the MSH contract. The last HFDP needs at this point is a re-

occurrence of past contracting difficulties. This makes the selection of the right individual for the Administrative Manager position all the more critical.

Regarding the UPecon Project Director, the time to lay this issue to rest is overdue. It would be in the project's best interests if a new Project Director acceptable to the Secretary and senior DOH managers were assigned by UPecon. The present Director seems to be pulled in too many directions due to his considerable professional and technical skills to devote sufficient time to the project. A mutually agreeable arrangement that would continue to make the technical expertise of the present Director available to the project should be encouraged, e.g., the present Director would become a UPecon consultant devoting fifty percent of his time to the project.

A more fundamental issue is involved with this situation. The difficulties the UPecon Project Director and Technical Coordinator on the MSH team have encountered stem from their involvement with the planning of HFDP when they were in office. There is no USAID regulation which bars individuals involved with planning future project activities while in the GOP to be hired to work on those same activities after leaving government service. One might very well question the soundness of the judgement which led to and maintained this situation in HFDP, but this is not a strictly legal issue. It is, however, an issue of the perceptions by subsequent managers of such arrangements and the effects of those perceptions on the ability of the individuals involved to provide consistent, effective contributions to a project. This suggests that USAID should follow similar rules which apply to former U.S. direct hire employees of A.I.D. for its own projects with respect to hiring former GOP officials.

### *Recommendations:*

1. The DOH should identify appropriate staff to be seconded for at least a day or two each week to work with technical advisors at the advisors' offices on specific HFDP activities to facilitate skills acquisition, technology transfer, etc.
2. As recommended earlier, MSH should assure that the person hired for the Administrative Manager position has a strong contracting background, i.e., extensive experience with U.S. Government or competitive contracting procedures.
3. With or without an extension of the UPecon cooperative agreement, UPecon and HFDP project managers should find a new Project Director who can devote full time to the project and has the full confidence of senior DOH officials. The present Director should be encouraged to remain engaged in HFDP through a standing part-time consultancy arrangement with UPecon.

4. USAID should consider a policy of higher Mission management review concerning the hiring of former GOP officials to work on USAID projects in which they were involved in the planning or implementation stages.

## Scope of Work Midterm Evaluation of the Health Finance Development Project

### *A. Background*

The Health Finance Development (HFD) Project, began on September 1991, reaches its midpoint on March 1994. The Project seeks to establish a process for formulating and implementing health care financing policies, regulations, and legislation supportive of health care market improvement in the Philippines. The Government of the Philippines (GOP) counterparts are the Department of Health (DOH) and the Philippine Medical Care Commission (PMCC).

The Project has three components: Component 1 - Policy Formulation - is concerned with the formation of capacity for research-based policy formulation and the establishment of mechanisms for an interactive and transparent health care financing policy process. This component is implemented through a Cooperative Agreement with the UPecon Foundation, a private non-stock entity based at the University of the Philippines School of Economics.

Component 2 - Health Care Financing Mechanisms - is concerned with improved efficiency and expanded coverage of the national health care financing programs in the Philippines. Component 3 - Hospital Financing Reforms - seeks to improve the efficiency and effectiveness of hospital-based care provided through public and private hospitals in the Philippines. Both components are implemented through an Institutional Contract with a consortium led by the Management Sciences for Health (MSH); other parties in this consortium are Andersen Consulting (AC), Corporate Assistance and Research Associates (GARRA), and the Harvard Institute for International Development (HIID).

In addition to the Cooperative Agreement and the Institutional Contract, the Project also provided for the services of a Personal Services Contractor, based at DOH, who is tasked with overseeing and orchestrating the entire Project.

Since the start of its implementation, the HFD Project has faced three major factors that altered project focus and profoundly affected project implementation. First, the Project straddled two DOH administrations. It was designed during the latter part of the incumbency of DOH Sec. Alfredo R.A. Bengzon and later Sec. Antonio O. Periquet. Following the presidential elections in May 1992, a new DOH Administration took over in June, headed by Sec. Juan Flavio Velasco who brought along a new set of upper-echelon DOH administrators.

Second, the new DOH leadership not only had a new set of health priorities; it also faced new challenges brought about by the recent enactment of the Local Government Code (which devolved most health services to local government units) and the Magna Carta for Health Workers (which sought to upgrade the salaries of civil servants involved in the delivery of health services).

Third, in 1993, as a result of drastic cuts in USAID resources to the Philippines, the Project was subjected to a budget reduction. USAID and DOH were forced to refocus Project objectives and begin reprogram activities in October-November, 1993. The refocusing resulted in the concentration of Project activities into five areas. Some of the activities in each of the five areas are new; the others are from the original design of the HFD Project.

- a. **National Health Insurance** - This set of activities includes developing recommendations on Medicare I reforms; developing recommendations on Medicare II; assistance in capacity building for PMCC; and assistance in the formulation of a National Health Insurance bill.
- b. **Devolution** - This set of activities includes developing recommendations on DOH fiscal policy toward devolution, operations of regional field monitoring offices, program assistance for devolved hospitals, and DOH policies for retained hospitals. It also includes assistance in the formulation of comprehensive health service agreements with local government units, and assistance in the revision of the implementing rules and regulation of the Magna Carta for Health Workers.
- c. **Public Resource Management** - This set of activities includes provision of technical assistance in the drafting of public investment plan in health; assistance in the drafting of the DOH strategic financial planning; developing recommendations on the financing of priority DOH programs; and assistance in the reorganization plan and the national health plan.
- d. **Standards, Licensing and Regulation (SLR)** - This set of activities includes developing recommendations on policies for retained hospitals, designing of improvements in hospital operations, and organizational development of SLR function in DOH.
- e. **Health Policy Process** - This set of activities includes the development of the national health accounts, the institutionalization of the Health Policy Development Staff of the DOH; support for the organization of the Multisectoral Health Policy Forum; the development of a health policy agenda; training; and publications.

This brief background provides the context in which the midterm evaluation will be carried out.

*B. Purpose of the Midterm Evaluation*

The purposes of this midterm evaluation are: (a) to examine the validity of the HFD Project in light of current developments in the Philippine health sector; (b) to assess the responsiveness of its management structure and its administrative and operational processes; and (c) to develop specific recommendations on how the Project implementors - the UPecon Foundation and the MSH Consortium - can best meet Project objectives for the remainder of the Project.

*C. Scope of the Evaluation and Data Sources*

The Midterm Evaluation will cover the entire period starting from project initiation until the time of the evaluation. It will cover the performance of all actors in the Project, namely:

- the DOH and PMCC;
- USAID, including the Office of Population, Health and Nutrition (OPHN), the Office of Financial Management (OFM), and the Contracts Services Office (CSO);
- UPecon Foundation and its subgrantees;
- the MSH consortium and its subcontractors;
- the Personal Services Contractor and HFD Project-funded staff.

The evaluation will include all elements of the Project, namely: (a) technical assistance; (b) training; (c) research; (d) demonstrations; (e) commodities; and (f) local costs.

*D. Key Evaluation Issues*

**Task 1 - Assessment of Project Validity**

For this task, the Evaluation Team is expected to answer the following:

What were the major objectives of the Project when it was designed? How have these objectives been revised as a result of the October 1993 refocusing of activities? Do these objectives remain appropriate in the context of the present needs of the Philippine health sector? Why or why not?

- Are Project strategies and activities appropriate to meet the revised objectives? Why or why not? If not, what modifications in strategies and activities are required to meet the objectives?
- What were the effects of external and unanticipated actions and/or events on the Project, such as change in DOH leadership, administration, and priorities; enactment and implementation of the Local Government Code and the Magna Carta for Health Workers; and reduction in the level of USAID resources? In light of these changes, what modifications are necessary to achieve revised objectives?
- To date, what impact on financing, access to and delivery of health services has the Project made or is likely to make over its life?
- Assess the overall implementing structure developed for the Project, i.e., through Cooperative Agreement, Institutional Contractor, and Personal Services Contractor. Is this structure appropriate? Given the present structure, what modifications are required to enhance Project management? .

#### Task 2 - Assessment of Management Structure and Processes -

For this task, the Evaluation Team is expected to answer the following:

- What is the extent to which GOP and private sector counterparts are accomplishing the revised Project objectives? How do you explain this pace in Project implementation vis-a-vis the schedule?
- What are the major constraints, weaknesses and vulnerabilities in Project implementation and how can these be remedied? What are its strengths and opportunities and how can these be maximized?
- Assess the administrative structures established by the Grantee, the Institutional Contractor and the DOH/PMCC to manage their respective Project activities. Are these adequate and responsive? How can Project management be improved at the Grantee and Institutional Contractor level?

#### Task 3 - Development of Recommendations for Project Improvement

For this task, the Evaluation Team is expected to:

- Develop a set of specific recommendations to improve Project management, both in terms of overall Project management and at the institutional level.

Develop a set of recommendations on how the Grantee and the Institutional Contractor can reprogram their resources and refocus their activities to best meet Project objectives.

#### *E. Data Sources/Report Format/Reporting*

The Evaluation Team is expected to review the following documents related to the design and implementation of the Project:

- USAID documents - project paper, project implementation letters, memoranda, minutes of meetings, etc.
- DOH and PMCC documents - administrative orders, department orders, minutes of PMCC Board meetings, and other documents relevant to the Project;
- Project documents - operational plans, Project directives, minutes of meetings, terms of references and scopes of work, commitment documents, etc.
- Project outputs - monographs, technical reports, etc.

The Evaluation Team is also expected to conduct individual and/or group interviews (focus group discussions) with persons directly involved with the Project, as well as a selected number of stakeholders.

The evaluation will address each of the questions stated in Section D. For each topic in turn, the evaluation report will present the major findings, the conclusions concerning what each of the findings mean or indicate about the topic being addressed, and recommendations for actions program managers should take based on the team's conclusions.

The evaluation Team will report to Patricia Moser or her designee. Reports will also be submitted to her.

#### *F. The Evaluation Team*

The midterm evaluation will require the services of a three-member team consisting of:

one Management/Evaluation Specialist (5 person-weeks), who will serve as Team Leader and be responsible for the overall evaluation and reporting requirements. S/he must have broad experience in the management and administration of USAID-funded

projects. S/he must be knowledgeable about the various modes, procedures, and requirements in USAID contracts and grants. S/he will assign tasks to and oversee inputs of other evaluation team members to ensure completion of Tasks 1-3, above.

- one Health Finance Specialist (2 person-weeks), who will be primarily responsible for review of project content and progress in technical areas. S/he must have a broad experience in the evaluation of health financing activities in health. Knowledge of health care financing issues in developing countries is required. S/he will be responsible for evaluating the impact of the project, determining its continuing validity according to the Project logical framework (logframe) and in the light of recent developments in the Philippine health sector, and identifying any required substantive modifications.
- one Institutional Analyst (2 person weeks), who will be primarily responsible for assessing the Project's DOH, USAID, and Contractor and grantee management structures, and identifying required modifications to improve Project administration.

The evaluation is estimated to take 1.5 calendar months to complete. This includes the briefings and debriefings that the Evaluation Team will provide for USAID, DOH, PMCC, the Institutional Contractor, and the Grantee. Estimated timing for this engagement is June 1994. A completed Final Report is required not later than August 31, 1994. A 6-day workweek is authorized with no premium pay.

*G. Expected Outputs and Time Frame*

- For Team Leader:
  1. Evaluation outline, with tasks and persons responsible by June 25, 1994.
  2. A draft report by July 15, 1994.
  3. Three copies of draft final report by July 19, 1994. This draft should be in English, double spaced, not exceeding 50 pages in length, including tables. It should include an Executive Summary not exceeding 3 pages.
  4. Three copies of final report which should reflect the comments of USAID, DOH, and PMCC, by July 29, 1994.

For Health Finance Specialist/Institutional Analyst:

1. A draft report of the assessment with recommendations by July 11, 1994.
2. A final draft report by July 15, 1994.

*Logistics*

Individual contractors are responsible for their own travel, office space, research assistance communications.

In addition, the Team Leader is responsible for draft and final report development and production as well as other eligible expenses associated with the completion of the midterm presentation.

## Individuals Interviewed

### DOH

Dr. Jaime Galvez-Tan, Undersecretary and Chief of Staff  
Dr. Juan Nanagas, Undersecretary Office for Hospitals  
Dr. Marl Mantala, Chief, HPDS  
Dr. Cecille Paulino, Chief, IPS  
Dr. Margarita Galon, Chief, HOMS  
Dr. Juan Perez, Chief, LGAMS

### USAID

Dr. Emmanuel Voulgaropoulos, Chief of O/PHN  
Patricia Moser, HFDP Project Officer and Chief of the Health and  
Nutrition Division  
Marichi de Sagun, HFDP Project Manager  
Dr. Thomas D'Agnes, HFDP Personal Service Contractor  
Annie Aristores, Contracts Officer, Office of Regional Procurement

### PMCC

Dr. Rodolfo Maceda, Executive Director

### UPecon

Mario Taguiwalo, Project Director

### MSH

Charles Stover, Chief of Party  
Rhais Gamboa, Technical Coordinator  
Dr. James Jeffers, Health Economist  
George Purvis, Hospitals Advisor

Lynn Almario, former MSH Insurance Specialist  
Oscar Picazo, former USAID Project Manager for HFDP

## I. REVISED PROJECT DESCRIPTION

### A. *Project Goal, Purpose and End of Project Status (EOPS)*

The goal of HFDP assistance remains the same: to develop the health care market in order to improve health service quality, equity, coverage, efficiency, and private participation.

The Project purpose also remains essentially the same: to establish a process for formulating and implementing health care financing policies, regulations and legislation supportive of health care market improvement. However, given the refocusing of Project activities and the reduced level of funding that will be available, the end-of-project status (EOPS) will be measured by a more precise set of indicators covering selected areas of performance:

1. Proposed legislation for a national health insurance program will be presented and debated in Congress
2. DOH capacity for health policy, strategic financial planning, and standards, licensing, and regulation will be established through institutionalization of the Health Policy Development Staff, systems development for budget and planning and organizational development of the standards, licensing and regulatory functions of the DOH.
3. Linkages will be created with stakeholder in local governments, other government agencies, the private sector, and Congress to formulate health policy through the development of a multisectoral health policy forum and the strengthening of the Department Legislative and Liaison Office (DLLO).
4. Health care expenditure patterns will be quantified and tracked through the establishment of a National Health Accounts.

The project outputs that will be produced, the activities that will be conducted, and the inputs that will be contributed by HFDP will be described in the following sections for each of the program areas.

### B. *Program Area 1: National Health Insurance*

The current compulsory medical insurance program, known as Medicare I, provides partial reimbursement for inpatient care for wage-based employees and their dependents. The Social Security System (SSS) administers the program on behalf of private-sector employees; the Government Service Insurance System (GSIS) administers it on behalf of civil servants and

government retirees. PMCC provides policy direction and oversight for both SSS and GSIS Medicare programs.

Organizational, administrative, and management deficiencies have impaired the effectiveness of Medicare I. The disjointed policy and management functions the PMCC, SSS and GSIS, have fragmented the program and caused administrative chaos. Inadequate claims processing, the absence of an eligibility system, fraud and abuse, and a host of managerial problems leave the program administratively cumbersome and grossly inefficient. As a result, The Medicare I program's ability to provide adequate financial support to covered members has been severely compromised.

Likewise, Medicare has been unable to extend medical insurance coverage to the informal non-wage based sector. The Medicare II program which was passed for that purpose, has never been implemented beyond sporadic, isolated, small scale pilot projects. As a consequence, health insurance coverage is almost non-existent in the nearly 40 million people comprising the non-wage based informal sector in the Philippines.

## 1. Project Outputs

The output for this program area is the development of plans and strategies for improved efficiency and expanded coverage of a national health insurance program. The activities in this program area are directed toward policy initiatives to extend prepaid health insurance benefits as currently embodied in the Medicare I Program, to the entire population. The Project will produce policy and organizational recommendations to improve Medicare I and II. Policy recommendations will be translated in a draft national health insurance (NHI) bill which extends coverage to all Filipinos, and in the evaluation of other NHI proposals.

## 2. Project Activities

- a. Policy Recommendations on Medicare I - The Project will support studies and consultations aimed at improving compliance to Medicare I; expanding health benefits under Medicare I through inclusion of outpatient services; improving physician payment through the development of a relative value scale; improving claims processing and reducing fraud and abuse; and restructuring the Medicare I program with the possible unification of functions currently dispensed by three entities.

The Project will also provide technical assistance and implementation support for the reduction of fraud; improvement of accreditation and licensure; formulation of HMO regulation; development of Medicare MIS; production of a monograph on the PMCC Health Data System; and organizational improvement and capacity building at the PMCC.

- b. Policy Recommendations on Medicare II - Project activities to achieve this output includes support for government-sponsored LGU-based health financing schemes in the provinces of Bukidnon, Quezon, and Guimaras; design of pilot scheme on employer-provided health benefits; and strategic planning on the coverage of the self-employed and the urban poor. Policy and management lessons from these pilot schemes will be culled for possible application in other settings.
- c. Drafting of a National Health Insurance Bill - Project activities involve support for the Technical Working Group formulating the NHI bill; consultative discussions and technical support during the legislative debate on the bill, including the regular "Medicare Miting" series; development of a spreadsheet model, dubbed the "First Principles" project, that estimates the financial cost of alternative assumptions on NHI coverage and benefit package; and evaluation of Medicare II pilot schemes.

### 3. Project Inputs

Project inputs will be in the form of studies, research, and technical assistance, and financial support for defraying workshop and consultation costs.

### C. *Program Area 2: Public Resource Management*

These activities help generate more resources for public health services and improve the allocation and efficient use of such resources. Public resource management at the DOH remains weak: the annual budget process lacks discipline and programmatic direction; budgeting is usually done on an incremental basis rather than on the basis of real needs; public investment criteria have a negative bias against health projects; priority DOH programs have been identified but have not been fully-costed; and the logistics system has not kept pace with the requirements of a devolved system of health service provision. On top of these, there is no overall national health plan.

#### 1. Project Outputs

The output for this program area is a demonstrated capacity for strategic financial planning in the health sector. To address major public resource management problems, the Project will produce recommendations and guidelines in public investment planning, strategic financial planning, financing of DOH priority programs, logistics improvement, and the national health plan.

## 2. Project Activities

- a. Guidelines for the Public Investment Plan - This output entails support for the preparation of a draft 10-year public investment plan which will be submitted to NEDA.
- b. Guidelines for DOH Strategic Financial Planning - This output will be realized through Project assistance to the Internal Planning Service of DOH in the development of strategic planning guidelines; conduct of orientation workshops for budget and finance officers; planning of 1994 and 1995 budgets; and conduct of performance and budget execution reviews.
- c. Recommendations on the Financing of Priority DOH Programs - This output entails the preparation of cost estimates of priority DOH programs; conduct of cost-effectiveness studies; and a study on DOH-LGU cost-sharing in health programs.
- d. Improvement in the DOH Logistics System - This output will be produced partly through a Project-funded study on the DOH logistics system, which will be used as basis for an investment plan on logistics improvement.
- e. Draft National Health Plan (NHP) - The Project will provide financial assistance to the NHP Secretariat.

## 3. Project Inputs

Project inputs will be in form of studies, technical assistance, and financial support.

### *D. Program Area 3: Devolution of Health Services*

Over the past two years, two legislative initiatives introduced major changes in the government health sector. The Magna Carta for Health Workers sought to upgrade the benefits of civil servants involved in the delivery of health care. The impact of this law was complicated by the passage of the Local Government Code (LGC) of 1991, which devolved health services (provincial and district hospitals, rural health units, and *barangay* or village health stations) and health personnel to local government units (LGUs), implying that the upgraded benefits mandated by the Magna Carta would be provided to health workers employed by the LGUs. The LGC, however, provided for continued central DOH management of "retained" regional hospitals and medical centers.

With the devolution, DOH functions in health service provision were dramatically reduced as these were turned over to LGUs. The turnover of these functions, however, required

strengthening of DOH roles in policy making, standard-setting, monitoring and the provision of technical assistance to LGUs. It also required the establishment of new fiscal and regulatory relationship between the DOH and LGUs.

## 1. Project Outputs

The output for this program area will be DOH policies on public health financing under the local government codes. Project activities include recommendations on macro issues such as fiscal policy on devolution, the implementation of the Magna Carta for health workers, assistance for devolved hospitals.

## 2. Project Activities

- a. Assistance to GOP in the Devolution of Health Services - The Project will assist GOP, both at the central DOH and at local government units, in the devolution process through the following activities:
- Formulation of Comprehensive Health Care Agreements (CHCA) between DOH and LGUs: CHCAs will be the primary instrument by which DOH can influence LGU provision of health services. The Project will assist the DOH in the preparation and update of its devolution strategy paper; the preparation of CHCA documents and conduct of prototype negotiations; and technical assistance to the Task Force on Devolution.
  - Fiscal Policy on Devolution: The Project will assist in crafting appropriate fiscal policies on devolution through studies that will determine LGU fiscal behavior and policy tools to influence such behavior. The Project will also support draft fiscal-policy proposals for legislative action.
  - Development of Recommended Guidelines for Regional and Provincial Health Offices under Devolution: The Project is supporting demonstration projects at the regional (Region VII) and provincial (Bohol Province) levels which seek to field-test mechanisms for health coordination and monitoring under devolution.
  - Conduct of a Pilot Course for LGU Managers: This is being arranged by the University of the Philippines - College of Public Administration under the auspices of the Project.
- b. Recommendations on the Implementation of the Magna Carta for Public Health Workers - The Project will support a study on the implementation of Magna Carta and will formulate a procedure for estimating its mandated benefits.

- c. Assistance to Devolved Public Hospitals - The Project will provide resources for the formulation of appropriate assistance to devolved hospitals. Project activities include a study to determine the effects of LGC on devolved hospitals; workshop for administrators of devolved hospitals; support for innovations in the management and/or ownership of devolved hospitals; assistance to LGUs on hospital management through a task order contract; and technical assistance support for devolved hospitals.

### 3: Project Inputs

Project inputs will be in the form of studies, technical assistance, and financial support.

#### *E. Program Area 4: Standards, Licensing, and Regulation*

Subsequent to the promulgation of the Local Government Code legislation, the entire DOH service delivery infrastructure was devolved to the local government units except for its 44 retained hospitals and the 12 Regional Health Offices. One of the principal responsibilities which has been retained by the DOH is setting health standards, licensing health facilities and establishments, and regulating the entire health sector.

The standards, licensing and regulatory function is not new to the DOH. There is a Bureau for Licensing and Regulation in the DOH which, prior to devolution, it performed this function for all health facilities in the country. Following devolution the DOH continues to accredit and license health facilities, but its enforcement capacity has been compromised in devolved facilities.

Under devolution, however, the scope of the standards, licensing, and regulation function will have to change substantially. The DOH must continue to provide direct financial support and management control over the 44 retained hospitals, which are the most sophisticated regional and specialty hospitals, and medical centers in the country during a period of budgetary restraint. It must continue to accredit and license all health facilities and hospitals with a concomitant capacity to enforce. But it must now expand beyond its orientation towards facilities and infrastructure, to setting standards and regulating training, health services, manpower, laboratory, diagnostics, etc. This will involve new roles, functions, capacities, qualifications of personnel, procedures, and organizational mandates.

#### 1. Project Outputs

The output for this program area will be DOH policies and standards for health facilities. Project activities will support the formulation of a DOH strategy for its retained hospitals, hospital financing policy reforms in retained hospitals, and protocols for improvements in

hospital operations. In addition the project will assist the DOH to develop strategic directions for the standards, licensing, and regulatory function in the future.

## 2. Project Activities

- a. Assistance to Retained Hospitals - The Project will support policy formulation activities for retained hospitals including a study to determine their "post-devolution" state; hospital strategic planning; a study on revenue enhancement in retained hospitals and formulation of guidelines on revenue retention; development and printing of a handbook for small hospital operations; and budget review of retained hospitals.
- b. Design Improvements in Hospital Operations - The Project will support a limited range of activities envisioned to improve hospital management and operations. These include design of quality assurance program for emergency rooms; support for health prevention/promotion activities in hospital settings; development of hospital manuals and training materials; development of manual for budget preparation in LGU hospitals; and design of prototype hospital MIS.
- c. Organizational Development of Standards, Licensing, and Regulatory function in the DOH - The project will support strategic planning for standards, licensing, and regulation, formulation of organizational structures, functions, and staffing that will be required by the DOH for its expanded role in standards, licensing, and regulation; develop manuals, training materials, and standards for specific hospital functions; and develop prototype methods for undertaking standards, licensing, and regulatory functions in the field.

## 3. Project Inputs

Project inputs will be in the form of studies, technical assistance, and financial support.

### F. Program Area 5: Health Policy Process

This area of concentration essentially carries over the output and activities of the original Component 1 - Policy Formulation.

#### 1. Project Output

The output of this program area is the formation of capacity for transparent, private/public sector, and interactive research-based policy formulation. This will be realized through the development of the National Health Accounts (NHA), development of a health policy

agenda, institutionalization of the Health Policy Development Staff (HPDS) at the DOH, operationalization of the Multisectoral Health Policy Forum, and training and publications.

## 2. Project Activities

- a. Development of the National Health Accounts - The Project will support the NHA Data Management Unit of UPEcon Foundation to develop approaches and document the methodology for estimating NHA; to collect and assess data for the NHA and to estimate NHA entries; and to train DOH counterparts in NHA accounting. The Project will also support a range of research and analytical activities related to the NHA, including assistance to local institutions participating in NHA development, preparation of life table estimates, and organization of research advisory team.
- b. Health Policy Agenda - Project assistance to achieve this output will involve the preparation of periodic Health Sector Reviews; the development of a health policy data base, a computerized compilation of health sector legislation; and conferences/seminars on health care financing.
- c. Institutionalization of the HPDS - The Project will provide assistance to the HPDS in drafting issuances on the DOH policy process; developing a health policy monitoring and evaluation plan; and formulating framework papers on policy monitoring. The Project will also assist DOH Legislative Liaison Officers (DLLO) in tracking legislation and communicating DOH policy decisions.
- d. Multisectoral Health Policy Forum - The Project will provide assistance to the Multisectoral Health Policy Forum in organizing the Forum and conducting policy discussions. It will also fund a study on private hospital incentives
- e. Training and Publications - Project activities will cover the conduct of four core courses (health economics, health care financing, cost/benefit and cost/effectiveness analyses in health, and health policy analysis); support for administration of the Project Training Plan; support for training institutions (the University of the Philippines' School of Economics, graduate fellowships, short-term overseas training, and workshops/seminars; and publications support.

## 3. Project Inputs

Project inputs will be in the form of studies, technical assistance, and financial support.